(7)

No. 96-110

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington, *Petitioners*,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D., *Respondents*.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED JULY 3, 1996
CERTIORARI GRANTED OCTOBER 1, 1996

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DOCUMENTS CONTAINED IN THE APPENDIX TO THE PETITION FOR WRIT OF CERTIORARI

The following opinions, decisions, judgments and orders have been omitted in printing this Joint Appendix because they appear on the following pages in the appendix to the printed Petition for Certiorari.

CHRONOLOGICAL LIST OF IMPORTANT DATES

January 24, 1994	Plaintiffs' Complaint for Declaratory Judgment and Injunctive Relief filed in U.S. District Court for the Western District of Washington at Seattle
February 3, 1994	Plaintiffs' Motion for Summary Judgment filed
February 19, 1994	Defendants' Answer to Complaint for Declaratory Judgment and Injunctive Relief filed
February 28, 1994	Defendants' Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment and in Support of Summary Judgment for Defendants filed
March 16, 1994	Oral argument on cross motions for summary judgment
May 4, 1994	Order Granting in Part and Denying in Part Plaintiffs' Motion for Summary Judgment and Denying Defendants' Cross Motion for Summary Judgment issued by District Court
May 19, 1994	Stipulation of Parties Regarding Finality of Appeal and Joint Motion for Entry of Final Judgment entered
May 20, 1994	Order Entering Final Judgment entered by District Court

May 25, 1994	Defendants' Notice of Appeal to the United States District Court filed
December 7, 1994	Oral argument before a three-judge panel of the United States Court of Appeals for the Ninth Circuit
March 9, 1995	Opinion of the three-judge panel of the United States Court of Appeals for the Ninth Circuit filed
August 1, 1995	Plaintiffs' Petition for Rehearing and Suggestion for Rehearing En Banc to United States Court of Appeals for the Ninth Circuit granted
October 26, 1995	Oral argument before limited en banc panel of the United States Court of Appeals for the Ninth Circuit
March 6, 1996	Opinion of limited en banc panel of the United States Court of Appeals for the Ninth Circuit filed
March 25, 1996	Order directing parties to brief the issue of whether the case should be reheard before the entire United States Court of Appeals for the Ninth Circuit entered
March 26, 1996	Defendants/Appellants Motion to Stay Mandate filed with the United States Court of Appeals for the Ninth Circuit
May 6, 1996	Order denying stay of mandate unless reconsideration by the entire Court is granted entered by the United States Court of Appeals for the Ninth Circuit

May 14, 1996	Honorable Sandra Day O'Connor, Associate Justice, grants 30-day extension for filing Petition for Writ of Certiorari until July 4, 1996
May 29, 1996	Order entered denying rehearing before the entire Court entered by United States Court of Appeals for the Ninth Circuit
	Order entered by the Honorable Sandra Day O'Connor, Associate Justice, directing that the mandate of the United States Court of Appeals for the Ninth Circuit be recalled and stayed
June 10, 1996	Order entered by the Supreme Court of the United States staying the mandate of the United States Court of Appeals for the Ninth Circuit pending disposition of petition for write of certiorari
June 12, 1996	Amended Order entered denying rehearing before the entire United States Court of Appeals for the Ninth Circuit, with three judges dissenting
July 3, 1996	Petition for Writ of Certiorari filed, docketed July 19, 1996 under cause No. 96-110
October 1, 1996	Order Granting Petition for Writ of Certiorari entered by the Supreme Court of the United States

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

INTRODUCTION

This action seeks a declaratory judgment of unconstitutionality and an injunction barring enforcement of the assisted suicide provision of RCW 9A.36.060. The relevant portion of the statute provides: "A person is guilty of promoting a suicide attempt when he knowingly . . . aids another person to attempt suicide." The statute--by making assistance by physicians, family, or others a felony--prevents competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid a lingering, painful death. The statute denies these individuals the liberty and privacy to decide what to do with their own bodies and lives and forces them to endure pain, anguish, and loss of dignity.

I. JURISDICTION AND VENUE

1.1 This action is brought under the United States Constitution and 42 U.S.C. § 1983 for violation of rights secured by the Fourteenth Amendment. The action seeks a declaratory judgment under 28 U.S.C. § 2201 and an order enjoining enforcement of the assisted suicide provision of the statute.

1.2 This Court has jurisdiction under 28 U.S.C. § 1331. Venue in this district is proper under 28 U.S.C. §§ 1391 and 2201.

II. PARTIES AND INTERESTS AFFECTED

2.1 Compassion in Dying ("Compassion") is a Washington nonprofit corporation. Compassion assists competent, terminally ill adults who choose to hasten their deaths. Plaintiff Jane Roe has requested the assistance of Compassion. Compassion provides information, counseling, emotional support, and personal presence at the time of death. Compassion operates pursuant to a stringent protocol, one requirement being that the medications be self-administered by the individual seeking to hasten death.

Compassion fears that a criminal prosecution could be brought against it for its activities in assisting dying persons to exercise their choice to hasten inevitable death.

2.2 Jane Roe is a mentally competent, terminally ill adult. Jane Roe is a 69-year-old resident of King County, Washington, who is dying of cancer. Jane Roe is a physician and understands her condition and prognosis. Her cancer has metastasized into her bones and is growing rapidly throughout her entire skeleton. She has undergone surgery, chemotherapy, and radiation therapy, but the cancer is incurable. Jane Roe has been almost entirely confined to bed for the past seven months. Movement is intensely painful and her muscles have become so weak they cannot support her. To attempt to alleviate the extreme pain associated with bone cancer, Jane Roe relies on increasing doses of morphine. Even so, she is frequently in severe pain. Jane Roe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of disease and that there is no chance of recovery. Jane Roe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Roe seeks necessary medical assistance in the form of medications prescribed by her doctor to be self-administered for the purpose of hastening her death. Jane Roe desires the presence of members of plaintiff Compassion when she acts to hasten her death.

2.3 John Doe is a 44-year-old artist, living in King County, Washington suffering from AIDS. Mr. Doe has a T-cell count of four, leaving him vulnerable to all manner of infections with almost no natural ability to fight them. Mr. Doe has cytomegalovirus retinitis, which has caused him to lose approximately 70% of his vision to date and will result in blindness. Loss of vision is fatal to Mr. Doe's vocation and avocation, painting. Mr. Doe has

been hospitalized for AIDS-related pneumonia on several occasions. Mr. Doe suffers from chronic skin infections, sinusitis and grand mal seizures related to AIDS. Mr. Doe experiences extreme fatigue and his ability to care for himself is rapidly diminishing. Mr. Doe served as the primary caregiver for his long-term companion who recently died of AIDS at home in Mr. Doe's care. Mr. Doe witnessed firsthand the pain, suffering and loss of bodily function, integrity and personal dignity the disease causes. John Doe has been advised and understands that his illness is a terminal one, that he is in the terminal phase of the disease and that there is no chance of recovery. John Doe desires medical assistance in the form of medications prescribed by his doctor to be self-administered for the purpose of hastening his death.

2.4 James Poe is a mentally competent, terminally ill adult. James Poe is a 69-year-old resident of King County, Washington, who suffers from chronic obstructive pulmonary disease ("COPD") involving emphysema, bronchitis, and asthma. James Poe also suffers from heart failure caused in part by his COPD. The COPD makes it extremely difficult for James Poe to get enough air. He is connected to an oxygen tank at all times and is required to aspirate medications for hours each day to assist his breathing. He regularly experiences panic attacks associated with the sensation of suffocating and must take medication to calm this terror. James Poe's heart failure causes swelling of his lower extremities, resulting in lost mobility and pain. James Poe's only comfortable moments in life are when he is asleep; however, he can only sleep for two to three hours at a time. James Poe saw his mother die a slow, agonizing death and desires to avoid such a death himself. James Poe has been advised and understands that his illness is a terminal one, that his illness is incurable, and that he is, or soon will be, in the terminal

phase of the disease. When death is imminent and his suffering too great, James Poe wants the right to choose to hasten his inevitable death with medications prescribed by his doctor for that purpose.

2.5 Harold Glucksberg, M.D., is a physician licensed in the State of Washington who practices medicine in a major medical center in Seattle. Dr. Glucksberg specializes in the care of patients with cancer. Many of his patients are terminally ill and suffer severe and chronic pain. Approximately five to ten percent of his patients have cancer related to AIDS. In the regular course of his medical practice, Dr. Glucksberg encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Glucksberg's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Glucksberg from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths. Dr. Glucksberg asserts his own constitutional rights and those of his patients.

2.6 Abigail Halperin, M.D., is a physician licensed in the State of Washington who practices family medicine in Seattle. Some of Dr. Halperin's patients are terminally ill. On occasion she encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Halperin's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Halperin from exercising her best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own

deaths. Dr. Halperin asserts her own constitutional rights and those of her patients.

2.7 Thomas A. Preston, M.D., is a physician licensed in the State of Washington who practices medicine in Seattle. Dr. Preston is a cardiologist and is Chief of the Cardiology Division at a major medical center. Dr. Preston treats patients who are terminally ill and, on occasion, encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Preston's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Preston from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths. Dr. Preston asserts his own constitutional rights and those of his patients.

2.8 Peter Shalit, M.D., Ph.D., is a physician licensed in the State of Washington who practices internal medicine in Seattle. Approximately thirty percent of his patients suffer from AIDS, an incurable disease. AIDS patients typically suffer from recurrent infections that wear the body down. Many AIDS patients develop cancer. Cancer of the lungs is common among AIDS patients, causing extreme shortness of breath and the terrifying sensation of suffocating. AIDS patients have typically witnessed the deaths of other persons from AIDS and are aware of the course the disease takes. Many of Dr. Shalit's competent, terminally ill patients express interest in voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Shalit's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Shalit from exercising his best professional judgment to prescribe medications to these patients in dosages that

would enable them to act to hasten their own deaths. Dr. Shalit asserts his own constitutional rights and those of his patients.

2.9 The State of Washington is a governmental entity.

2.10 The Attorney General of the State of Washington, Christine Gregoire, is the chief law enforcement officer of the State of Washington and acts under color of the law in enforcing RCW 9A.36.060. She is sued in her official capacity and as representative of all law enforcement officers in the State.

2.11 There exists an actual, justiciable controversy among these parties as to the validity of the statute.

III. CAUSES OF ACTION

3.1 The Fourteenth Amendment protects the right of competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

3.2 The Fourteenth Amendment protects the right of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

3.3 RCW 9A.36.060 denies plaintiffs the equal protection of the laws by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise

this choice, with necessary medical assistance, by directing termination of such treatment.

3.4 Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. Plaintiffs continue to undergo unnecessary pain and anguish. Absent expedited consideration and prompt injunction against enforcement of RCW 9A.36.060, plaintiffs will continue to suffer substantial and irreparable harm and their rights will be finally and fully denied before this Court can rule.

IV. PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

4.1 A declaration that the assisted suicide provision of RCW 9A.36.060 is invalid under the United States Constitution.

4.2 A declaration that the assisted suicide provision of RCW 9A.36.060 violates 42 U.S.C. § 1983.

4.3 An order permanently enjoining defendants, and all who act in concert with them, from enforcing the assisted suicide provision of RCW 9A.36.060.

4.4 An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. § 1988.

4.5 Such other and further relief as this Court deems just.

DATED: January 24, 1994.

PERKINS COIE
David J. Burman
Thomas L. Boeder

By /s/
Kathryn L. Tucker
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	DECLARATION OF RALPH MERO, M.DIV., D.D.
Defendants.	)	

RALPH MERO declares:

1. I am the Executive Director of Compassion in Dying, a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am an ordained Unitarian Universalist minister with graduate degrees from Meadville Lombard Theological School at the University of Chicago. I have been employed in parish ministry with a local congregation and also in community miniseries in health care administration. I am an experienced counselor and trainer of counselors, and have extensive experience in dealing with the personal, familial, and societal aspects of death and dying.

3. Compassion in Dying is a nonprofit charitable organization incorporated in Washington State in April 1993 for the purpose of providing information and counseling to mentally competent, terminally ill adult patients--and their families--in situations where the patients are considering the option of hastening inevitable death. These services are provided at no charge.

4. Terminally ill patients contact Compassion in Dying seeking assistance in shortening the period of suffering before death, and all end-of-life decisions are made by the patient. The family must concur with the patient's decision to hasten death in order for Compassion to be involved. These hastened deaths are facilitated by drugs obtained by, and self-administered by, the patient.

5. Compassion in Dying has stringent eligibility requirements and provides its services only to individuals who are determined by independent medical judgment to be mentally competent and in the end stage of their disease. The eligibility criteria of Compassion are contained in our Guidelines and Safeguards and are set forth as Exhibit 1.

6. Compassion in Dying has stringent Protocol describing the process for assisting with the hastened deaths

of eligible individuals. That Protocol is set forth as Exhibit 2.

7. With members of our Board of Directors, I have been present at several hastened deaths when requested by terminally ill patients and their families. Our presence is provided so that these patients do not have to die alone or to provide emotional support for any family members who are also present.

8. Plaintiff Jane Roe has requested my presence and that of one of our Board members at the time she acts to hasten her death. She is eligible under our criteria. An interview I conducted with Jane Roe on January 20, 1994, about her medical condition and her desires regarding her dying process was video recorded. Plaintiff Jane Roe is very desirous that her true identity not be divulged to the press and public. A complete and unedited copy of that recording will be submitted as soon as a protective order is entered prohibiting disclosure of Jane Roe's true identity.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 1st day of February, 1994.

/s/
RALPH MERO, M.Div., D.D.

COMPASSION IN DYING
PO Box 16483 - Seattle, WA 98116 - 202/624-2775

GUIDELINES AND SAFEGUARDS FOR ASSISTED SUICIDE

A. GUIDELINES

1. Who is eligible?
   a. The patient's condition must be considered terminal in the judgment of the patient's primary-care physician; i.e., the patient suffers from an incurable condition which, according to reasonable medical judgment, will result in death within a reasonable period of time, regardless of continued treatment.
   b. The patient's condition must cause severe, unrelenting suffering which the patient finds unacceptable and intolerable.
   c. The patient must understand the condition, prognosis, and types of comfort care which are available as alternatives to suicide.
   d. The patient's condition and prognosis must be confirmed by one or more physicians who review the records and examine the patient, to the extent that these are possible without compromising the dignity of the patient.
2. Quality of care being received.
   a. It must be clear that the patient's suffering and request for assisted suicide are not the result of inadequate hospice or comfort care.

   b. It must also be clear that the patient's request for assisted suicide is not motivated by lack of adequate health insurance or other economic concerns.
3. The process of requesting assistance.
   a. The request for assistance with suicide must originate with the patient. The request must be made in writing or on videotape on three (3) occasions, with an interval of at lest 48 hours between the second and third requests.
   b. All requests and records will be kept confidential.
   c. Any indication of uncertainty or ambivalence on the part of the patient will cancel the process leading toward assisted suicide.
   d. Requests may not be made through advance directives or by a health-care surrogate, attorney-in-fact, or any other person.
4. Mental health considerations.
   a. Evaluation by a mental-health professional may be obtained to ensure that the patient's request is not motivated by depression, emotional distress, or mental illness.
   b. The patient must be capable of understanding the decision and its implications and must take responsibility for the decision.
5. Family and religious considerations.
   a. If the patient has family members or others with whom he or she is in close personal relationship, their approval must be obtained. Assistance with suicide will not be provided

if there is expressed disapproval by members of the immediate family.

b. Spiritual and emotional counseling may be offered or arranged, depending on the patient's background and beliefs.

6. Who can assist?

The patient may ask for and receive assistance from the individuals in whom he or she has the most confidence and with whom he or she is the most comfortable. Volunteer health-care personnel and others will develop a relationship with the patient in order to become assured that a hastened death is the most appropriate outcome, given the condition and suffering of this particular patient.

B. <u>SAFEGUARDS</u>

1. Terminally ill persons who meet the medical, emotional, and situational criteria for assisted suicide, as outlined in the Guidelines for Assisted Suicide, must make a documented request for assistance with their own suicide, stating in detail the nature of the assistance they need.

2. Three requests must be made. The patient's initial request for assistance must be made in writing or on videotape. This must be followed by two additional requests in writing or on videotape, with at least 48 hours between the second and third requests. Such requests cannot be made through advance directives or by health-care surrogates, family members, or persons other than the patient.

3. COMPASSION representatives trained in working with the terminally ill will meet with the patient making the application--and his or her immediate family, if possible. Copies of the patient's medical records and other pertinent information will be requested.

4. The consulting physician will, through examination of the patient and review of the medical records, verify both the terminal prognosis and the patient's decision-making capacity. This may include consultation with the patient's primary-care physician. The consulting physician will be Board certified or will have equivalent professional experience.

5. If the physician reviewing the case determines a need to rule out depression or any other emotional factors which may indicate confused judgment, the physician shall request an evaluation by a qualified mental-health professional. In such an instance, no effort to assist with suicide will proceed until the assessment has been made and has confirmed the patient's capacity to understand the situation, and until the physician is convinced that the decision is both voluntary and rational. During the course of this process, the patient may receive in-depth counseling and emotional support, but there shall be no effort to assist with suicide during this review.

6. The reviewing physician will ascertain that the request for assistance with suicide does not result from inadequate hospice, palliative, or comfort care, or from inadequate efforts to control pain. If unmanaged pain is an issue, alternative or more intensive palliative care will be recommended.

7. Any sign of indecision or uncertainty on the part of the patient, or opposition on the part of the immediate family, will cancel the process leading toward assisted suicide.
8. The physician and others who have reviewed the records and interviewed the patient will meet in case conference to consider if assistance is needed and warranted. The decision of this group to proceed with assistance must be unanimous.
9. The patient may request that representatives of COMPASSION be present during his or her suicide to provide emotional support and assist with the patient's predetermined plan for ending life. If this is requested, two representatives of COMPASSION will be present. One will keep a written record of the times and events leading up to the moment of death.
10. The actual means of suicide will vary according to the underlying condition of the terminally ill patient and the types of medication available. Assistance with suicide under these safeguards will not involve any means of hastening death which rely on violence.
11. Following an assisted suicide, ongoing emotional and/or spiritual support will be offered to surviving family members or others who so request. Information may also be provided about grief and bereavement resources available in the community.
12. To assure that the process of dying is humane and respectful of the patient's innate sense of human dignity, there shall be no breach of confidentiality disclosing the identity of a patient who has

received assistance with suicide or the identity of persons who provided assistance.

COMPASSION IN DYING

PO Box 16483 - Seattle, WA 98116 - 202/624-2775

PROTOCOL FOR ASSISTED DYING

1. Receipt of initial request for information from patient or family, usually by phone.

2. Personal interview with patient, and family if possible, by Executive Director or Board member to explore alternatives and make preliminary determination that patient meets the requirements for assistance from COMPASSION. During this interview, the patient may complete the **FIRST FORMAL REQUEST FOR ASSISTANCE**, in writing or videorecorded.

3. Assignment of Case Review Team (CRT) consisting of:

    1. Executive Director or substitute from Board of Directors
    2. Nurse, mental health professional, or other person experienced in working with the terminally ill.
    3. Trained volunteer, selected to serve as primary liaison with patient, plus physician from Advisory Committee to serve as consultant to CRT.

4. Provision of counseling and emotional support, with second exploration of alternatives.

    Patient must continue determination to commit suicide as only appropriate course of action.

5. **MEDICAL REVIEW.** Examination of patient and medical records by an independent physician to confirm that patient meets medical requirements for assistance from COMPASSION. Consultation with primary care physician, if at all possible.

6. First review by CRT and report to Executive Director or a Board Review Committee appointed for this purpose.

7. **SECOND FORMAL REQUEST FOR ASSISTANCE** from patient, followed by further counseling and emotional support. Third exploration of alternatives. Discussion of specific plan for suicide by prescription medications.

8. Second review by CRT and report to Board Review Committee, if patient plans to continue with suicide.

9. **THIRD FORMAL REQUEST FOR ASSISTANCE** from patient. *At least 48 hours must transpire between 2nd and 3rd requests.*

10. Third review by CRT and report to Board Review Committee.

    Development of plan for assistance, with clear understanding of COMPASSION'S limits and agreement of family members.

11. Further counseling to be sure that patient wishes to proceed with suicide.

    Fourth review of alternatives.

12. Presence at the time of death if patient is determined to commit suicide and so requests.

COMPASSION IN DYING PROTOCOL FOR ASSISTED SUICIDE

1. Receipt of initial request for information from patient or family, probably by phone.
2. Personal interview with patient, and family if possible, by Executive Director or Board member to explore alternatives and make preliminary determination that patient meets the requirements for assistance from COMPASSION. During this interview, the patient may complete the FIRST FORMAL REQUEST FOR ASSISTANCE, in writing or videorecorded.
3. Assignment of three person Case Review Team (CRT) consisting of:
    1. Executive Director or substitute from Board of Directors
    2. Nurse, mental health professional, or other person experienced in working with the terminally ill.
    3. Trained volunteer, selected to serve as primary liaison with patient, plus physician from Advisory Committee to serve as consultant to CRT.
4. Provision of counseling and emotional support, with second exploration of alternatives.
   Patient must continue determination to commit suicide as only appropriate course of action.
5. **MEDICAL REVIEW.** Examination of patient and medical records by an independent physician to confirm that patient meets medical requirements for assistance from COMPASSION. Consultation with primary care physician, if at all possible.

6. First review by CRT and report to Executive Director or a Board Review Committee appointed for this purpose.
7. **SECOND FORMAL REQUEST FOR ASSISTANCE** from patient, followed by further counseling and emotional support. Third exploration of alternatives. Discussion of specific plan for suicide by prescription medications.
8. Second review by CRT and report to Board Review Committee, if patient plans to continue with suicide.
9. **THIRD FORMAL REQUEST FOR ASSISTANCE** from patient. *At least 48 hours must transpire between 2nd and 3rd requests.*
10. Third review by CRT and report to Board Review Committee. Development of plan for assistance, with clear understanding of COMPASSION'S limits and agreement of family members.
11. Further counseling to be sure that patient wishes to proceed with suicide.
    Fourth review of alternatives.
12. Presence at the time of death if patient is determined to commit suicide and so requests.
13. On-going emotional support for the family, if requested.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C91-119
Plaintiffs,	)	DECLARATION OF JANE ROE
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

JANE ROE declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. Jane Roe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 69 years old and am a pediatrician. I received my medical degree from Vanderbilt Medical School in 1953. I have been married for 38 years to my husband who is also a physician. We have 2 grown children.

4. In 1973 a lump in my right breast was determined to be malignant. I underwent surgery to remove my right breast. I then underwent chemotherapy to further treat the breast cancer.

5. To my knowledge, I was free of cancer until the fall of 1988. Efforts to stop the cancer since then have not succeeded. At this time, the cancer has metastasized into my bones and is now found throughout my skeleton, including my skull, spine, rib cage and pelvis.

6. I underwent radiation therapy with fairly good results until early 1993, at which point the cancer became much more painful. Surgery is not an option and chemotherapy cannot be repeated due to bone marrow depression.

7. Beginning in June 1993 and continuing to the present, I have been almost entirely bedridden due to a combination of pain associated with the cancer in my bones and the diminishing strength in my muscles as I use them less and less. I am now unable to walk or use the commode or a bed pan without assistance. My legs are swollen with severe edema and I can scarcely use them. I have developed bed sores as a result of being bed bound. My appetite is poor and I take medications to prevent nausea and vomiting. My vision is often impaired. My left hand is weak. Drowsiness is a frequent problem. I

have an indwelling urinary catheter and am sometimes incontinent of bowel.

8. The pain associated with this cancer is unrelenting. It is a constant, dull pain, interspersed with sharp, severe pain provoked by movement. The site of pain moves as the disease advances.

9. I take a variety of medications to manage pain. There is a tension between taking enough medication to alleviate the pain and retaining an alert mental state. It is not possible to eliminate my pain and for me to retain an alert state.

10. I have experienced a variety of adverse side effects with each treatment regimen. Chemotherapy caused bone marrow depression, fatigue, severe bladder irritation, diarrhea and nausea. Radiation caused further bone marrow depression, requiring repeated blood transfusions; severe bleeding; diarrhea; fatigue; severe sore throat; and first degree skin burns. My medications cause severe constipation, drowsiness, difficulty concentrating, and dry mouth.

11. Since the cancer was diagnosed to the present I have pursued medical treatment. The fact that both I and my spouse are doctors has enhanced my understanding of my condition and options. I believe that I have received good treatment and have benefited from it. At this point, it is clear to me, and based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures. The sole medical treatment available is pain relief, which is not able to eliminate my frequent and severe pain.

12. In November 1993 my doctor referred me for hospice care, and I am receiving home hospice care. To be eligible to receive hospice care I must have no more than six months life expectancy.

13. At the point at which I can no longer endure the pain and suffering associated with my cancer I want to have drugs available for the purpose of hastening my death. I no longer am licensed to prescribe drugs myself, and do not know the best combination of substance and dosage.

14. At the time I act to hasten my death I would like members of Compassion in Dying to be with me and members of my family to provide counseling, emotional support, and any necessary ancillary assistance, such as mixing the drugs to be consumed. I do not want to have to die alone and unsupported. I have made three formal written requests to Compassion in Dying for their assistance as is required by that organization. I participated in a video-taped interview conducted by Ralph Mero of Compassion in Dying on January 20, 1994, which I understand will be submitted in this proceeding. That interview also accurately describes my medical condition and my desires with regard to my dying process.

15. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Mercer Island, this 1st day of February, 1994.

_____

A/K/A JANE ROE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF JOHN DOE
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

JOHN DOE declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. John Doe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 44 years old and am an artist.

4. I was diagnosed HIV positive in 1988 and diagnosed with AIDS in 1991. I have a T-cell count of 4, which means I have almost no immune system function.

5. My first major illness associated with AIDS was pneumocystic carinii pneumonia, which caused me to be hospitalized for approximately six weeks in the summer of 1992.

6. I experienced a second bout with AIDS-related pneumonia, nocardia, in January 1994. This illness required hospitalization for a period of almost two weeks.

7. I have had cytomegalovirus (CMV) retinitus [sic] since May 1993. This is destroying my retinas, and I am losing my vision. At the present time, I have lost 70% of my vision. I have been advised that I will lose 100% of my vision from this condition.

8. Loss of vision is fatal to my ability to paint.

9. I suffer chronic, severe sinus infections which I am unable to overcome because of my compromised immune state.

10. Also related to my AIDS, I suffer chronic skin infections and grand mal seizures.

11. In addition, my medical conditions leave me extremely fatigued. I live alone and I have noticed that my ability to care for myself is rapidly diminishing.

12. My long-term companion died of AIDS in June 1991. He was bedridden for six months prior to his death. He remained at home throughout his illness, and I was his

primary caregiver. He suffered from wasting syndrome, and at the time of his death he weighed only 60 pounds. I cared for his every physical need. I witnessed first-hand the pain, suffering, anguish, and loss of dignity of dying from AIDS. That experience, as well as my observation of my grandfather's death from diabetes, which included multiple amputations, loss of vision and loss of hearing, have led me to decide that when my inevitable dying process becomes unbearable, I wish to hasten that process.

13. My doctor has advised me that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

14. It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death.

15. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at [not legible], this 1st day of February, 1994.

_____

A/K/A JOHN DOE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	DECLARATION OF JAMES POE
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

JAMES POE declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. James Poe is not my real name; I use this fictitious name to protect my privacy.

3. I am 69 years old. I was a sales representative in the steel industry for all of my working life. My hobby of choice was fishing and, until my illness, I was an avid fisherman year-round.

4. I have suffered from emphysema for approximately nine years. My emphysema makes it extremely difficult for me to breathe. I have a constant sensation of suffocation.

5. In 1990, I underwent lung capacity testing and my doctor advised me that I had only 10 to 20 percent of lung function at that time.

6. I am connected to an oxygen tank at all times and I aspirate medications through a nebulizer for hours every day to facilitate my breathing.

7. Notwithstanding these measures to improve my breathing, I continue to be unable to get enough air and suffer panic associated with air hunger. I take medications, including morphine, regularly to calm the terror associated with the sensation of suffocation.

8. In addition to my emphysema, I suffer from heart failure related to my pulmonary disease. This condition obstructs the flow of blood to my extremities. I experience extreme leg pain and discomfort and am housebound.

9. The only comfortable times are when I am asleep. However, I have difficulty sleeping longer than two to three hours at a time.

10. Because of my condition, I am restricted to my home and have been for the past year.

11. I am not eligible for lung transplant because of my heart condition.

12. My doctors have advised me that I am in the terminal phase of this disease. It has been explained to me that there are no cures.

13. When my condition becomes unbearable, I wish to take drugs prescribed by my doctor for the purpose of hastening my death.

14. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end of life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Wa., this 1 day of Feb. 1., [sic] 1994.

_____

A/K/A JAMES POE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF HAROLD GLUCKSBERG, M.D.
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

HAROLD GLUCKSBERG declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in oncology, which is the treatment of persons with cancer.

3. I received my medical education at the Buffalo Medical School in the State of New York, graduating in 1964.

4. I completed a Fellowship in hematology and oncology in the Department of Medicine at the University of Washington School of Medicine in Seattle, Washington in 1970.

5. I then completed a Senior Fellowship in oncology in the Department of Medicine at the University of Washington School of Medicine in Seattle, Washington in 1971.

6. I served as an Instructor and Senior Fellow in Medicine at the University of Washington School of Medicine in Seattle, Washington from 1971 through 1973.

7. During the years 1973 through 1975, I served as Assistant Professor of Medicine at the University of Washington School of Medicine.

8. From the years 1975 through 1976, I served as a Senior Lecturer in the Department of Medicine at the University of Dar Es Salaam in Tanzania, Africa.

9. I then served as Assistant Professor in Medicine at the University of Washington School of Medicine in Seattle, Washington and held that position through 1979.

10. During the years 1976 through 1979, I was an Assistant Member of the Fred Hutchinson Cancer Research Center in Seattle, Washington.

11. I served as an Attending Physician in the emergency departments of three New York hospitals during the years 1980 through 1982.

12. I acted as Regional Medical Officer for the Peace Corps in Senegal, Mali, Gambia, and Mauritania during the years 1982 through 1984.

13. Since 1985, I have practiced primary care adult medicine specializing in medical oncology at the Pacific Medical Center in Seattle, Washington. During this period, I have also served as Clinical Assistant Professor at the University of Washington School of Medicine.

14. I am certified by the National Board of Medical Examiners (1965), the American Board of Internal Medicine (1974), and the American Board of Medical Oncology (1979). I am licensed to practice medicine in Washington, New York and New Jersey.

15. I have published numerous articles and papers in medical journals. My full curriculum vitae is attached hereto as Exhibit 1.

16. Dying of cancer is usually very slow, occurring over months rather than days or weeks. General problems faced by most cancer patients include progressive loss of appetite, weight, and independence, and increasing pain and fatigue. In addition, there are a myriad of other problems related to the specific sites of the cancer. Those with cancer of the lung, for example, face terrible shortness of breath and cough. Those with a brain cancer often have excruciating headaches, seizures and progressive loss of brain function. Cancer usually progresses steadily and slowly. The cancer patient is fully aware of his or her present suffering and anticipates certain future suffering. The terminal cancer patient faces a future that can be terrifying. Near the end, the cancer patient is usually bedridden, rapidly losing mental and physical functions, often in excruciating, unrelenting pain. Pain management at this stage often requires the patient to choose between enduring unrelenting pain or surrendering an alert mental

state because the dose of drugs adequate to alleviate the pain will impair consciousness. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.

17. I occasionally encounter patients dying of cancer who have no chance of recovery, whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to hasten their deaths and avoid prolonged suffering. These patients cannot hasten their death without assistance or could do so but only at the risk of increased pain and anguish to themselves and their families.

18. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

19. Under the statute prohibiting assisting suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should.

20. One patient of mine, whom I will call Jones, a fictitious name, was a 34-year old man dying of AIDS and lymphoma. I treated him during the last year of his life, the final four months of which were excruciatingly painful. Patient Jones had wasted away and suffered from CMV retinitis, which causes blindness. Patient Jones did not want to end his days in a lingering drug-induced stupor, the option available to him if he entered the hospital and was given continuously increasing amounts of morphine intravenously. Patient Jones requested that I prescribe drugs that he could take to hasten his inevitable death. As his

treating doctor, it was my professional opinion that patient Jones was competent to choose to shorten his period of suffering before death by taking drugs prescribed for that purpose. I felt that I should accommodate his request by prescribing such drugs. However, because of the statute I was unable to assist him in this way. Patient Jones ended his life by jumping from the West Seattle bridge. His physical condition was such that he could not have accomplished this without assistance, and it is my belief that he was aided by close family members. Such a violent end of life is inhumane for the patient and for his loved ones. In my opinion, patient Jones suffered more by dying in this manner than he would have if he had been able to self-administer drugs prescribed for the purpose of hastening his death.

21. Furthermore, patient Jones ran the risk of failing in his effort to hasten his death without medical assistance and could have suffered grievously if his effort had been unsuccessful.

22. Another patient of mine, whom I will call Smith, a 60-year-old man dying of metastatic lung cancer, was suffering terribly and requested that I prescribe drugs that he could take to hasten his inevitable death. Patient Smith was opposed to experiencing a lingering death with consciousness impaired by morphine. As his treating doctor, it was my professional opinion that patient Smith was competent to choose to shorten his period of suffering before death by taking drugs prescribed for that purpose. I felt that I should accommodate his request by prescribing such drugs. However, because of the statute, I was unable to assist him. Patient Smith's death dragged on for seven days, most of which was spent in a morphine-induced stupor, exactly as he had feared and desired to avoid.

23. The statute kept these patients from making fundamental decisions about medical care, their lives, their suffering and their dignity. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Washington, this 2nd day of February, 1994.

/s/
HAROLD GLUCKSBERG, M.D.

Name: Harold Glucksberg, M.D.

Birthdate:	October 18, 1939
Birthplace:	Montreal, Canada
Domestic Status	Married, 2 children
Citizenship:	Naturalized, 1957, Brooklyn, New York

Education:

1956 - 1957:	City College of New York
1957 - 1960:	Queens College of New York
1960 - 1964:	M.D., Buffalo Medical School, New York

Research and Professional Experience:

1964 - 1965:	Internship in Medicine, King Country Hospital,New York City
1965 - 1966:	Resident in Medicine, King Country Hospital New York City
1966 - 1969:	Internal Medicine, U.S. Army
1969 - 1970:	Fellow in Hematology and Oncology, Department of Medicine, University of Washington School of Medicine, Seattle, Washington
1970 - 1971:	Senior Fellow in Onocology [sic], Department of Medicine, University of Washington School of Medicine, Seattle, Washington

EXHIBIT 1

1971 - 6/73:	Instructor and Senior Fellow in Medicine, University of Washington School of Medicine, Seattle, Washington
7/73 - 6/75:	Assistant Professor of Medicine, University of Washington School of Medicine
7/75 - 6/76:	Senior Lecturer, Department of Medicine, University of Dar Es Salaam, Tanzania, Africa, (Sabbatical)
7/76 - 12/79:	Assistant Professor of Medicine, University of Washington School of Medicine, Seattle, Washington
8/76 - 12/79:	Assistant Member, Fred Hutchinson Cancer Research Center, Seattle, Washington
4/80 - 10/80:	Assistant Professor of Nutrition, Tulane Medical School, Co-Director National Nutrition Center of Zaire
10/80 - 7/81:	Attending Physician, Emergency Center Maimonides Medical Center, Brooklyn, New York
9/81 - 7/82:	Attending Physician, Emergency Center, Coney Island Hospital, Brooklyn, New York
1/82 - 7/82:	Attending Physician, Emergency Department, Brooklyn Jewish Hospital, Brooklyn, New York
8/82 - 11/84:	Regional Medical Officer for Peace Corps (Senegal, Mali, Gambia and Mauritania)
1/85 - Present:	Primary Care, Adult Medicine, Medical Oncology Pacific Medical Center, Seattle, Washington

Clinical Assistant Professor University of Washington, School of Medicine

Military Status:

1966 - 1969: Internal Medicine, U.S. Army

Honors:

Gibson Honor Society; Mosby Book Award

Board Certification:

1965	Diploma of the National Board of Medical Examiners
1974	American Board of Internal Medicine
1979	American Board of Medical Oncology

Licensure:

Washington, New York, New Jersey

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Harold Glucksberg, M.D.

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF ABIGAIL HALPERIN, M.D.
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

ABIGAIL HALPERIN declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in family medicine and practice in Seattle, Washington.

3. I received my medical education at Albert Einstein College of Medicine in New York, completing my degree in 1983. Following graduation from medical school I completed a family practice residency at Swedish Hospital Medical Center in Seattle, Washington.

4. I then served as a staff physician at an international clinic in Kathmandu, Nepal from 1986 until 1987.

5. In 1987 I became a staff physician at Pacific Medical Clinic in Bellevue, Washington.

6. In 1988 I moved my practice to Uptown Family Practice in Seattle, Washington, which became Providence Uptown Medical Care Center in May 1992, where I continue to practice. I hold the position of Medical Director and Staff Physician.

7. I am licensed to practice medicine in the state of Washington; am certified by the American Board of Family Practice (1988); and am a member of the King County Medical Society and the American Academy of Family Physicians.

8. I hold an appointment as a Clinical Faculty member at the University of Washington School of Medicine, a position I have held since 1990.

9. In my medical practice, I occasionally treat patients with terminal illnesses, including cancer and AIDS.

10. Patients dying of both these diseases experience a steady degeneration of functional ability, increasing pain, fatigue and mental anguish.

11. At a certain point in the progression of many cancer patients' illness, there are no further curative treatment options. There are no curative treatment options for AIDS patients.

12. When curative treatments are not available, a variety of care options to maximize the patient's well being and comfort are available, however, at a certain point in the course of these diseases most patients are not able to be kept comfortable while maintaining a clear consciousness; the amount of pain medication necessary to resolve the pain causes loss of mental alertness and sometimes consciousness. Thus, these patients face the choice of enduring intractable pain or surrendering an alert mental state. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor.

13. For some terminally ill patients, physical pain is a concern secondary to their mental anguish over their helplessness and loss of independence, dignity and autonomy.

14. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to shorten the period of suffering before death. These patients either cannot hasten their death without assistance or could do so only at the risk of increased anguish and pain to themselves and their families.

15. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death as

an alternative to continuing palliative care if the patient so chooses.

16. Under the statute prohibiting assisted suicide, my fulfillment of this professional responsibility might expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should and deprives my patients of their freedom to choose this type of medical care.

17. I recently had an experience where, in my professional judgment, a terminally ill patient of mine should have been able to choose to hasten her inevitable death with drugs prescribed for that purpose but was denied that option by the statute:

a. Patient Smith (a fictitious name) was a woman in her eighties with metastatic breast cancer.

b. Patient Smith had surgeries to remove both breasts and two courses of chemotherapy.

c. Notwithstanding this aggressive surgical and medical treatment, the cancer metastasized and was causing progressive weakness, fatigue and loss of functional abilities.

d. Patient Smith had always been active and independent; she expressed that she did not want to lose her independence and end her life in a hospital, subject to futile medical care; she desired the ability to control the manner and time of her death and requested that I prescribe drugs that she could take to hasten her inevitable death.

e. As patient Smith's primary care doctor, it was my professional opinion that she was mentally competent to choose to shorten the

period of suffering before death. I felt that I should accommodate her request by prescribing such drugs. However, I was deterred from assisting this patient by the statute.

f. Patient Smith acted on her own to hasten her death, by securing a plastic bag over her head and suffocating.

g. In my opinion it is likely that patient Smith suffered more by dying in this manner than she would have if she had been able to self-administer drugs prescribed for the purpose of hastening her death.

h. Furthermore, patient Smith ran the significant risk of failing in her effort to hasten her death without medical assistance and could have suffered disastrous consequences if her effort had been unsuccessful, such as oxygen deprivation-induced brain damage, which would have left her significantly mentally impaired and dependent on the type of intensive, invasive medical care and technology she most feared.

i. The statute kept patient Smith from making fundamental decisions about her medical care, her life and autonomy, her suffering, her dignity, and her death. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 2 day of February, 1994.

/s/
ABIGAIL HALPERIN, M.D.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	DECLARATION OF THOMAS A. PRESTON, M.D.
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

THOMAS A. PRESTON declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am a medical doctor specializing in cardiology and am Chief of Cardiology at Pacific Medical Center in Seattle, Washington.

3. I received my medical education at the University of Pennsylvania, graduating in 1962.

4. Following graduation from medical school I completed an internship, residency and fellowship at the University of Michigan.

5. I served as a Special Research Fellow at the National Heart Hospital Institute of Cardiology in London, England, during 1967 and 1968.

6. Upon my return to the United States in 1968 I served as an Instructor of Internal Medicine, specializing in cardiology, at the University of Michigan through 1969. I then became Assistant Professor of Medicine at the University of Michigan and served in this capacity through 1972.

7. I served as Chief of the Cardiology Section at the Veterans Administration Hospital in Ann Arbor, Michigan, from 1968 through 1972.

8. From 1973 until 1980 I served as Associate Professor of Medicine at the University of Washington. Since 1980 I have held the position of Professor of Medicine at the University of Washington.

9. I served as Co-Director of the Division of Cardiology at Harborview Medical Center, Seattle, Washington from 1973 through 1975.

10. From 1975 through 1980 I served as Co-Director of cardiology at the United States Public Health Service Hospital in Seattle, Washington.

11. From 1980 through the present I have been Chief of the Cardiology Division at Pacific Medical Center in Seattle, Washington.

12. I have received numerous honors for medical teaching and writing and have published numerous articles and books in my field of professional expertise. My complete curriculum vitae is attached hereto as Attachment 1.

13. I am board certified in Internal Medicine (1971) and Cardiovascular Medicine (1974).

14. I am currently licensed to practice medicine in Washington. I am a Fellow of the American College of Cardiology and the American Heart Association Council on Clinical Cardiology.

15. In my medical practice I regularly treat patients dying from cardiopulmonary illnesses. Such patients commonly experience chest pain, breathlessness, dizziness, fainting and extreme weakness. The heart of this type of patient is so weak it can work no harder than it does at rest, rendering the patient unable to accomplish the smallest physical task or able to do so only with extraordinary effort, gasping for air. It is not uncommon, for example, for such patients to be unable to change position in bed. There is no chance of recovery for such patients unless a heart transplant, a treatment option available to only a small subset of patients, is performed. The terminal phase of heart failure can last for several months, and most patients know during that time that they are not eligible for a transplant.

16. I occasionally encounter terminally ill patients who have no chance of recovery, whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis, who desire to hasten their deaths and avoid prolonged suffering, and who cannot do so without

assistance or could do so but only at the risk of increased anguish and pain to themselves and their families.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

18. Under the statute prohibiting assisted suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statute has caused me to do less than I otherwise would for these patients.

19. The statute has resulted in patients of mine dying tortured deaths.

20. The following example is illustrative of situations I have experienced in my career:

a. Patient Jones (a fictitious name) had been in my care for approximately four years.

b. Patient Jones suffered for three months in the final stages of heart disease, unable to get enough air, gasping even under an oxygen mask worn at all times.

c. Patient Jones requested my assistance in hastening his inevitable death by prescribing drugs he could take for that purpose.

d. Patient Jones was not eligible for a transplant, and had no chance of recovery. The patient understood this.

e. Patient Jones was suffering terribly, and the suffering could not be relieved. It was my professional opinion as his treating doctor that patient Jones was mentally competent to make a choice with respect to shortening his

period of suffering before inevitable death. I felt I should accommodate his request.

f. Nonetheless, I was deterred from assisting patient Jones by the statute.

g. The statute kept the patient from making fundamental decisions about the patient's own medical care, his life, his suffering and his dignity. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, this 1 day of February, 1994.

/s/
THOMAS A. PRESTON, M.D.

CURRICULUM VITAE

THOMAS A. PRESTON, M.D.
SSN# 198-24-8933

Birth Date: June 17, 1933

Birthplace: Philadelphia, Pennsylvania

Citizenship: U.S.A.

Education:		
	Swarthmore College Swarthmore, Pennsylvania,	1951-55
	University of Pennsylvania Philadelphia, Pennsylvania	1958-62
	B.S. Electrical Engineering	1955
	M.D. University of Pennsylvania	1962

Marital: Married (Molly), two daughters

Military Service:

U.S. Army	1956-58

Postgraduate Training:

Internship:	University of Michigan Medical Center	1962-63
Residency:	University of Michigan Internal Medicine	1963-66
Fellowship:	University of Michigan	1966-67
Specialty:	Special Research Fellow National Heart Hospital Institute of Cardiology London, England	1967-68

ATTACHMENT 1

Faculty Positions:

Instructor in Internal Medicine (Cardiology), University of Michigan	1968-69
Assistant Professor of Medcicine [sic] University of Michigan	1969-1972
Associate Professor of Medicine University of Washington	1973-1980
Professor of Medicine University of Washington	1980-

Hospital Positions:

Chief, Cardiology Section Veterans Administration Hospital Ann Arbor, Michigan	1968-1972
Co-Director, Division of Cardiology Harborview Medical Center Seattle, Washington	1973-1975
Co-Director, Cardiology U.S.P.H.S. Hospital Seattle, Washington	1975-80
Chief, Cardiology Division Pacific Medical Center Seattle, Washington	1980-

Honors:

American College of Cardiology Young Investigator Award Second Place	1966
University of Michigan Medical Center Resident Achievement Award	1966
University of Michigan Medical School Senior Class Award for Best Teacher	1970, 1972
University of Michigan	1971

Distinguished Service Award	
University of Michigan Medical Center Resident Award to Outstanding Faculty Teacher	1972
University of Washington Medical School Senior Class Award to Outstanding Clinical Teacher	1974,75, 1977,78
The National Association of Science Writers "Science-in-Society" Journalism Award	1983

Administrative Service:

University of Michigan Medical School Senior Counselor	1970-72
University of Michigan Medical School Mentor, Class of 1974	

Board Certification:

Diplomate, American Board of Internal Medicine	1971
Subspecialty Board Certification: Cardiovascular	1974

Licensure:

Pennsylvania (inactive)	1963
Michigan (inactive)	1964
Washington	1973

Organizations:

Fellow
American College of Cardiology

Fellow, American Heart Association
Council on Clinical Cardiology

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF PETER SHALIT, M.D., Ph.D.
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

PETER SHALIT declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of Washington in 1985.

3. Prior to obtaining my medical degree, I received a Ph.D. in Genetics from the University of Washington in 1981. While pursuing my Ph.D. I served as a National Science Foundation Fellow and a National Institute of Health Trainee.

4. After obtaining my medical degree I completed an internship in the Department of Psychiatry and a residency in the Department of Medicine at the University of Washington in Seattle, Washington.

5. From 1989 to 1990 I served as Chief Medical Resident at Providence Medical Center in Seattle, Washington.

6. Since 1990 I have been in private practice specializing in general internal medicine in Seattle, Washington. I hold staff privileges at Swedish Hospital Medical Center and Providence Medical Center.

7. I am certified by the American Board of Internal Medicine (1989) and am licensed to practice medicine in the State of Washington.

8. I have served as the Medical Director of the Seattle Gay Clinic since 1989.

9. I have served as a Clinical Instructor in Medicine in the Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington since 1990.

10. I have served as Attending Physician at the Madison Clinic, an HIV clinic affiliated with Harborview Medical Center in Seattle, Washington, since 1990.

11. A substantial portion of my private practice involves treatment and care of persons with HIV infection and AIDS.

12. Infection with HIV, the Human Immunodeficiency Virus, produces progressive destruction of the immune system, leading to a condition known as the Acquired Immune Deficiency Syndrome, or AIDS, which is inevitably fatal. Persons with AIDS are vulnerable to a variety of unusual infections, cancers, and other syndromes such as dementia (progressive loss of cognitive function), wasting (chronic diarrhea/weight loss), and peripheral neuropathy (nerve damage causing burning or shooting pain in the limbs). Death is often preceded by a prolonged period of illness and debility, especially as medical science becomes better at preventing and treating AIDS-related infections.

13. Patients with AIDS may die in many different ways. Many suffer from Kaposi's Sarcoma, a common AIDS-related cancer. These patients frequently die from invasion of this cancer into the lungs, causing progressive difficulty breathing and ultimately death by suffocation. Many die of pneumonia, which also causes the patient to essentially suffocate. Many with wasting or dementia basically die of starvation and dehydration, a process that can take weeks and can be excruciating; some of the patients lose so much weight that they appear skeletal and their bones may break through their skin. Still others die as the result of some massive infection that resists treatment.

14. Many AIDS patients who will die of the above-described causes also suffer from conditions which themselves cause extreme pain and suffering. Examples include CMV retinitis, which leads to loss of vision and eventually blindness; neuropathy, which sometimes causes

pain so agonizing that it can be relieved only by a dosage of narcotics which impairs consciousness; Kaposi's Sarcoma of the skin, which can produce severe disfigurement and pain from swollen tissues and open, weeping skin lesions.

15. Medicines can palliate the dying process in many cases. The majority of the time, I am able to ameliorate the symptoms of a dying patient so that the patient can be relatively free from pain and discomfort while dying. However, in some cases, the pain, discomfort, and loss of dignity can be relieved only with drugs which render the patient unconscious; in some cases even such aggressive use of drugs does not bring relief. In my five years of practice I have had numerous AIDS patients receiving hospice care who repeatedly express frustration at how long the process is taking, and how painful, uncomfortable, and humiliating it is. Some of these patients have made repeated requests that their dying process be hastened.

16. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to hasten their death and avoid prolonged suffering. These patients cannot hasten their death without assistance, or could do so but only at the risk of increased anguish and pain to themselves and their families.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

18. Under the statute prohibiting assisted suicide, fulfillment of this professional responsibility might expose

me to criminal prosecution. The statute deters me from treating these patients as I believe I should.

19. The statute has resulted in patients of mine dying tortured deaths.

20. One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares. Patient Smith's agonies could not be relieved by medication or by the excellent nursing care he received. Patient Smith begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that patient Smith was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the statute, I was unable to assist him and he died after having been tortured for weeks by the end-phase of his disease.

21. Such a prolonged dying period is inhumane to the patient, who must suffer against his wishes, and to the loved ones, who frequently express the belief that "we are kinder to our pets than we are to the terminally ill." After death, the survivors have guilt about the suffering their dying loved-one endured, and the doctor feels remorse that the patient's suffering could not have been better relieved.

22. More than once I have had an AIDS patient commit suicide relatively early in the course of the disease, apparently fearing that a death like patient Smith's will be their fate. Feeling unable to discuss their fears with me or with their family, and anticipating an illness which will end in unrelieved suffering without the possibility of assisted

voluntary exit, these individuals prematurely end their lives on their own, usually through a violent means. They leave behind grief-stricken family members who have not had the opportunity to say good-bye, and a doctor who wishes he could have prevented their premature death by committing to help them through the subsequent stages of their illness, including the promise of provision of the means of release from unbearable suffering should they so choose at that time.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 1st day of February, 1994.

/s/
PETER SHALIT, M.D., Ph.D.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF KATHRYN L. TUCKER
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

KATHRYN L. TUCKER declares:

1. I am counsel to plaintiffs in this matter, am competent to testify and do so of my own personal knowledge.

2. The three terminally ill plaintiffs in this lawsuit appear with fictitious names. These individuals desire that their true identities not be revealed.

3. In support of Plaintiffs' Motion for Summary Judgment, declarations of each of the terminally ill plaintiffs are submitted.

4. The signature page of the declaration of each terminally ill plaintiff has been redacted to conceal the true name of the plaintiff. The originals of each of these signature pages are maintained at my office. This is necessary to maintain the privacy of the terminally ill plaintiffs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 2 day of February, 1994.

/s/
KATHRYN L. TUCKER

No. 88-605

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1988

WILLIAM L. WEBSTER, et al.,
Appellants,

v.

REPRODUCTIVE HEALTH SERVICES, et al.,
Appellees.

On Appeal from the United States Court of Appeals for the Eighth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN FERTILITY SOCIETY, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN SOCIETY OF HUMAN GENETICS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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EXHIBIT A

Accordingly, the statute is unconstitutional. See *Colautti v. Franklin*, 439 U.S. 379 (1979).

B. Section 188.205 of the Missouri statute, which the court of appeals held literally precludes a physician from "consulting," i.e., making any comment, about having an abortion unless necessary to save the mother's life, is unconstitutional. The statute clearly interferes with a physician's ethical obligations to discuss fully and accurately all information necessary to permit the patient to make an informed treatment choice. By mandating "a state-imposed blackout on the information necessary to make a decision" (851 F.2d at 1080), Section 188.205 forces a constitutionally impermissible "straightjacket" upon the physician's efforts fully to inform his or her patient. *City of Akron*, 462 U.S. at 445; *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

ARGUMENT

I. INDIVIDUALS HAVE A FUNDAMENTAL RIGHT TO MAKE DECISIONS ABOUT THEIR MEDICAL CARE, AND STATE LAWS WHICH INTERFERE WITH THAT RIGHT CAN BE JUSTIFIED ONLY IF THEY ARE NARROWLY TAILORED TO FURTHER A COMPELLING STATE INTEREST.

Appellants and their *amici curiae*--particularly the United States--ask this Court to overrule a decision interpreting the Constitution: *Roe v. Wade*, 410 U.S. 113 (1973). In so doing, they ask the Court to take two major steps. First, they propose altering the balance struck previously by the Court between the interests of the pregnant woman and those of the state. Second, they ask the Court to declare that no fundamental privacy right exists in this case at all. They make this second, extraordinary request because they believe that the privacy right

recognized in *Roe* cannot properly be derived from the Constitution. See U.S. Brief at 9-24.

Given the diversity of views of *amici's* members, this brief does not take a position on whether the balance of interests struck in *Roe* should be modified. However, *amici* firmly believe that the Court should reject the invitation of the federal government to deny constitutional protection to the well-established right of privacy that this Court applied in *Roe v. Wade*.

In the first place, the holding of this Court on the privacy issue was a common sense application of settled constitutional principles to a situation where a woman must make an individual choice about a matter which the Court found would have profound implications for her health and life. Since the same profound individual implications the Court identified in 1973 still exist (see *supra* at 3-23), the decision should be reaffirmed. Second, the holding on the privacy issue simply reflected the historic tradition, embodied in our common law, of recognizing that all medical treatment decisions ordinarily should be made by the patient, after consultation with a physician concerning the risks and benefits of treatment. Third, the holding on the privacy issue is fully consistent with the holdings of this Court in applying other abstract constitutional principles to medical treatment situations, where the Court has always respected the dignity of the individual and his or her right to obtain desired medical care. Each of these reasons independently supports the Court's holding that the decision to terminate a pregnancy implicates a fundamental right.

A. The Individual's Fundamental Privacy And Liberty Right To Be Free Of Governmental Interference Extends To Medical Treatment Decisions.

This Court has long recognized that, as part of the "liberty" protected by the Constitution's Due Process Clauses, the Constitution guarantees to each individual certain areas or zones of privacy which remain free from unjustified government interference or intrusion. See *Carey v. Population Serv. Int'l*, 431 U.S. 678, 684 (1977). The Court's privacy rulings rest on the theory that the constitutional text does not, on its face, specify all rights that warrant constitutional protection from executive or legislative intervention.[27]

The essence of the liberty interest denominated as the right to privacy is the concept that an individual in certain circumstances has a right to be let alone, *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), and that the individual must thus have "independence in making certain kinds of important decisions."

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[27] The concept of "liberty" in the Due Process Clause of the Fourteenth Amendment is a "broad" one. *Board of Regents v. Roth*, 408 U.S. 564, 572 (1972). For this reason, it has long been recognized as protecting certain personal choices. *See, e.g., Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).

Moreover, privacy is hardly the only value that has received constitutional recognition without being expressly specified in the constitutional text. For example, this Court found a right to travel in the Constitution without requiring any explicit textual basis. *Shapiro v. Thompson*, 394 U.S. 618 (1969). In addition, although "federalism" is nowhere mentioned in the Constitution, the doctrine is part of the constitutional scheme. *See Coyle v. Smith*, 221 U.S. 559, 565 (1911); *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

Whalen v. Roe, 429 U.S. 589, 599-600 (1977). As this Court has recognized, that right encompasses matters concerning marriage and procreation. The specter of governmental agents unnecessarily interfering with such inherently private, individual decisions is antithetical to basic concepts of individual liberty in a free society. See *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Loving v. Virginia*, 388 U.S. 1 (1967); *Eisenstadt v. Baird*, 405 U.S. 438 (1972). See also *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).[28]

Moreover, and of particular significance to *amici* and their members, the right to privacy which is derived from the concept of liberty also encompasses the right of an individual to make decisions about his or her medical care and treatment. As our discussion of the health implications of pregnancy and abortion makes clear, the Court's assumptions about the importance of this particular medical treatment decision are as true today as they were in 1973. Women face physiological and psychological risks and burdens when they become pregnant. Under this Court's decisions, individual choices become fundamental rights because they have a powerful and perhaps irreversible

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[28] The United States seems to accept *Griswold v. Connecticut*, 381 U.S. 479 (1965), as a legitimate decision on the ground that enforcement of a statute prohibiting the use of contraceptives would require wholly impermissible governmental prying into the private lives of individuals. (U.S. Brief at 12 n.9.) Having accepted *Griswold*, however, the government's textual theory (U.S. Brief at 23-28) for rejecting *Roe v. Wade* collapses, because this Court did not locate the right recognized in *Griswold* in a specific constitutional provision and could not, as the United States suggests, have located it in the Fourth Amendment alone. *See Carey v. Population Serv. Int'l*, 431 U.S. 678, 687 (1977). The United States' brief therefore bears "witness that the right of privacy which passes for recognition here is a legitimate one." *Griswold*, 381 U.S. at 485.

impact on who we are and who we will become. See *Fitzgerald v. Porter*, 523 F.2d 716, 719-20 (7th Cir. 1975): "These cases do not deal with the individuals' interest in protection from unwarranted public attention, comment, or exploitation. They deal, rather, with the individual's right to make certain unusually important decisions that will affect his own, or his family's destiny." Accordingly, it seems plain that the health effects of pregnancy and abortion, by themselves, should be sufficient to support the holding in *Roe* that the woman's choice should be constitutionally protected.

In holding that the abortion decision involved a fundamental right, the Court correctly noted that considerations of protecting the woman's health were vital. Specifically, the Court observed that:

> The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved.

Roe, 410 U.S. at 153. Similarly, in explaining the basis for the protections afforded first trimester abortions, the Court identified the important health concerns implicated by the woman's choice. "[U]ntil the end of the first trimester mortality in abortion may be less than mortality in normal childbirth . . . . This means . . . that . . . the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." *Id.* at 163. See also *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 429 n.11 (1983).

The full extent of the importance attached to the pregnant woman's interest in being able to preserve her life and health is perhaps most apparent, however, in the

context of third trimester abortions. At this stage, the State's interest in protecting fetal life is considered compelling. *Roe*, 410 U.S. at 163-165. Nonetheless, this Court has recognized that protection of the pregnant woman's health interests is still considered "paramount." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 769 (1986). Consequently, while *Roe* otherwise permitted proscription of third trimester abortions, it did not do so in instances where abortion "is necessary to preserve the life or health of the mother." *Roe*, 410 U.S. at 163-164.

The importance of the health considerations underlying *Roe's* holdings has led this Court to observe:

> In concluding that the freedom of a woman to decide whether to terminate her pregnancy falls within the personal liberty protected by the Due Process Clause, the Court in *Wade* emphasized the fact that the woman's decision carries with it significant personal health implications--both physical and psychological. . . . [I]t could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in *Wade*.

Harris v. McRae, 448 U.S. 297, 316 (1980).

To the extent that the right in this case depends upon the importance to the woman of the consequences of her choice (see *supra* at 3-23), the decision whether or not to have an abortion should be considered a fundamental right.

B. This Court's Recognition That Every Individual Has A Fundamental Right To Make Decisions About His Or Her Medical Treatment Is Supported By The History And Traditions Of This Nation.

The Court's treatment of the woman's choice as a protected interest under the Constitution is supported by more than a common sense application of this Court's liberty and privacy rulings to the medical facts surrounding abortions. The Court's handling of the constitutional status of a medical treatment decision by the individual is also supported independently by the traditional respect this nation has always granted to the individual's interest in making personal medical treatment decisions in consultation with a physician.

The substantive guarantees afforded by the Due Process Clause encompass the protection of interests that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.). In deciding whether a particular interest is so embedded, the Court's judgment has historically been informed by whether the interest was protected at common law. The Court has stated that the liberty guaranteed by the Fourteenth Amendment encompasses "the right of the individual . . . to enjoy those privileges long recognized in common law as essential to the orderly pursuit of happiness by free men." *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

In this regard, it is significant that: "No right is held more sacred, [n]or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person." *Union Pacific Ry. v. Botsford*, 141 U.S. 250, 251 (1891). An individual's interest in being permitted to make personal decisions

affecting bodily security, free from government coercion, is thus a traditionally protected interest.[29]

The interest in protecting the physical security and health of one's body is an ancient one. Blackstone classified this interest as one of the three principal articles--later embodied in our Constitution as "life, liberty and property" --constituting the "rights of the people of England." "[T]he preservation of a man's health from such practices as may prejudice or annoy it . . . are rights to which every man is entitled. . . ." W. Blackstone, *Commentaries* 1:134 (1765).

Indeed, both the common and statutory law of this country have consistently recognized the importance of the individual's interest in being able freely to make decisions designed to limit risks to his or her own health. In the law of torts, this interest is reflected, for example, in the requirement of informed consent to medical treatment. The principle which supports this doctrine is that the patient has a right to weigh whatever risks attend the particular treatment and to decide if they are intolerable.

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[29] Our general tradition of protecting the individual against coerced medical decisions posing a threat to health is more relevant than the narrow history of abortion regulation for determining the fundamental rights issue before this Court. That history of abortion is misleading because restrictions on the practice arose during an era when the procedure was dangerous. As noted in *Roe*, 410 U.S. at 148-49, "when most criminal abortion laws were first enacted, the procedure was a hazardous one for women . . .[;] [a]bortion mortality was high." Even then, abortion was frequently permitted when superceding [sic] health risks were present, *e.g.*, when necessary to preserve the life of the woman. *Id.* at 138-39. However, "[m]odern medical techniques have altered this situation," as this Court recognized in *Roe*, *id.* at 149, so that abortion restrictions that once served to protect the woman's health could now jeopardize her health. *See supra* at 8-13.

> The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .'

Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (quoting *Schloendorff v. Society of New Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.)). Accord *Natanson v. Kline*, 186 Kan. 393, 410, 350 P.2d 1093, 1106, *clarified*, 187 Kan. 186, 354 P.2d 670 (1960); F. Harper & F. James, *The Law of Torts* § 17.1 (2d ed. 1986).

Similarly, in order to guard the patient's ability to take steps essential to protecting his or her health, virtually every state in this country has recognized a physician-patient privilege. "The rationale of this privilege is to promote health by encouraging a patient to fully and freely disclose all relevant information which may assist the physician in treating the patient." *Huzjak v. United States*, 118 F.R.D. 61, 63 (N.D. Ohio 1987). See 8 J. Wigmore, *Evidence* § 2380a (McNaughton ed. 1961).

These examples illustrate this country's long-standing tradition of treating potential infringements upon an individual's ability to protect his or her health and autonomy with the utmost seriousness. That tradition is, in turn, constitutionally reflected in the Due Process Clause's substantive protection of life and liberty. "[T]he right to personal security constitutes a 'historic liberty interest' protected substantively by the Due Process Clause." *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982). Accord *Ingraham v. Wright*, 430 U.S. 651, 673 (1977) ("Among the historic liberties so protected was a right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security"). For that reason, the right to protect

one's bodily security, and to make medical decisions to that end, has always been deemed to require more than a mere minimal justification for government infringements. Under those principles, a woman's choice whether or not to terminate her pregnancy should be deemed a fundamental liberty interest protected by the Due Process Clause.

C. This Court's Recognition That Every Individual Has A Fundamental Right To Make Decisions About His Or Her Medical Treatment Is Supported By This Court's Approach To The Protection Of Health Under Specific Constitutional Provisions.

The United States criticizes (U.S. Brief at 12) the holding that a woman has a fundamental right embodied in the liberty component of the Due Process Clause to choose the medical treatment that she wishes her physician to provide as not "rooted in accepted principles." But the legal reasoning that supports the right in this context is essentially the same as the approach taken by this Court in applying other constitutional provisions, with language that is equally inexact, to issues concerning the provision of medical treatment generally. Thus, in the Fourth Amendment context, this Court has held that "our society recognizes a significantly heightened privacy interest" when government interference in medical decisions creates any increased risk to individual health. *Winston v. Lee*, 470 U.S. 753, 767 (1985).

In *Winston*, the government sought to perform a surgical procedure to remove a bullet from a criminal defendant's body. Presented with conflicting evaluations of the risk of the surgery, the court of appeals concluded that "the statistical risk of actual physical harm . . . is . . . very low [and could] be considered minimal." *Lee v. Winston*,

717 F.2d 888, 900 (4th Cir. 1983). Nonetheless, this Court reasoned:

> The operation sought will intrude substantially on respondent's protected interests. The medical risks of the operation, although apparently not extremely severe, are a subject of considerable dispute; *the very uncertainty militates against finding the operation to be "reasonable."*

Winston, 470 U.S. at 766 (emphasis supplied). The Court held that, in the absence of compelling countervailing interests, the very possibility of even marginal medical risk precluded the endangering government action. *Id.* As a matter of constitutional interpretation, the *Winston* Court's derivation of a privacy interest from the Fourth Amendment's general protection against "unreasonable searches and seizures" to protect a patient's medical treatment choice cannot be distinguished from the *Roe* Court's derivation of a privacy interest from the liberty clause to protect a conceptually identical right to make a medical treatment choice.

Similarly, the constitutional value attached to protection of personal health is also evident in this Court's decisions under the Eighth Amendment. This Court has held that the Eighth Amendment's proscription of cruel and unusual punishments is violated by "deliberate indifference to serious medical needs of prisoners." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). Thus, even an individual whose liberty interest has been constitutionally abridged retains a privacy right to receive medical care as part of the abstract protection against cruel and unusual punishment. Again, there is no basis for arguing that the process of recognizing this fundamental right of a prisoner to receive medical care is derived from anything more concrete or more settled

than the right to make an individual treatment decision which can be drawn from the Due Process Clause.

Not only is the process of analysis under these other provisions similar to what *amici* propose here for the Due Process Clause, but also the entire fabric of the Court's holdings regarding medical treatment decisions reflects a basic pattern in the Constitution which supports the right asserted in this case. See *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 259 (1974) (medical care constitutes "a basic necessity of life"). Repeated protection for a right under disparate sections of the Constitution indicates that the right is fundamental to and underlies the design of the Constitution itself. That is the case here.

The consistent close scrutiny by this Court of government attempts to interfere with personal interests in health and bodily security is not inadvertent. Rather, it demonstrates that these interests warrant the "fundamental" constitutional status that they have been granted throughout this Court's decisions. In sum, the Court should reaffirm both that there is a right of privacy generally incorporated into the "liberty" component of the Due Process Clauses and that the right extends to individual medical treatment decisions, including whether or not to terminate a pregnancy.

D. State Interference With A Fundamental Right Triggers Searching Judicial Examination Pursuant To The Compelling State Interest Test.

State "interference" with or "infringement" of a fundamental right triggers a searching judicial examination pursuant to the compelling state interest test. See *Roe v. Wade*, 410 U.S. at 155; *City of Akron*, 462 U.S. at 427. See also, *Shapiro v. Thompson*, 394 U.S. 618 (1969); *Miami Herald Publishing Co. v. Tornillo*, 418 U.S. 241

(1974). A state law which infringes a fundamental right is "presumptively unconstitutional," *Harris v. McRae*, 448 U.S. 297, 312 (1980) (quoting *Mobile v. Bolden*, 446 U.S. 55, 76 (1980)). It cannot withstand judicial scrutiny unless the state has a "compelling interest" and, in the abortion context, two elements of the compelling state interest test are met: the specific means chosen must be "reasonably related" to the state's compelling goals and thus consistent with sound medical practice; and those specific requirements must be carefully tailored to the state's purposes. Failure to satisfy either of these elements is fatal to the state's effort to infringe the woman's fundamental right. *City of Akron*, 462 U.S. at 426-31.

In much fundamental rights adjudication, a holding of infringement will doom a law because the state has no constitutionally recognized "compelling interest" in such an infringing enactment. In the abortion context, however, this Court has clearly recognized two "compelling" goals which can justify regulation of the decision whether or not to terminate a pregnancy. Thus, the state has a compelling interest in protecting the mother's health. *Roe v. Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428. Similarly, the state has a compelling interest in preserving the potential life of the fetus. *Roe v. Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428.

However, the presence of a compelling purpose does not, *ipso facto*, ensure the constitutionality of the state's particular infringement of the fundamental right. As the Court explained in *City of Akron*, 462 U.S. at 434, "the existence of a compelling state interest in health, however, is only the beginning of the inquiry." Thus, a state's requirements must be "reasonably relate[d]" to the compelling goals. *Roe v. Wade*, 410 U.S. at 163; *City of Akron*, 462 U.S. at 434 n.19 (quoting *Doe v. Bolton*, 410 U.S. 179, 194 (1973). Typically, this "reasonably related"

element of the test involves an inquiry into whether the state's requirements have a reasonable medical basis. "The State's discretion to regulate . . . does not, however, permit it to adopt abortion regulations that depart from accepted medical practice." *City of Akron*, 462 U.S. at 431. See *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 487 (1983) (Powell, J.); *Planned Parenthood v. Danforth*, 428 U.S. 52, 78-79 (1976).

Second, state laws that interfere with or burden the right must be carefully tailored to the state's objective. See *Roe v. Wade*, 410 U.S. at 165; *Planned Parenthood v. Ashcroft*, 462 U.S. at 485 n.8; *City of Akron*, 462 U.S. at 438. The law must, in other words, not be overbroad and must, therefore, advance the compelling state interest without any additional and unnecessary interference with the fundamental right. *City of Akron*, 462 U.S. at 438-439.

Application of the compelling state interest test and its elements, and the striking of any balance between fundamental rights and compelling state interests, ultimately turns, of course, on the nature of the fundamental rights that are involved. The United States, however, proposes that in determining the permissible scope of state interference with the abortion decision, under either a "compelling interest" or "undue burden" analysis, this Court should only take account of the effects of such interference on the woman's "interest in procreational choice." U.S. Brief at 22 n.16. This proposed approach is deeply flawed. It suggests that the Court should ignore the woman's fundamental interest in medical treatment decisions. Instead, abortions would be permitted only if the woman was "coerced" into becoming pregnant.

The United States' proposed analysis leaves no room for the woman to terminate a pregnancy to protect her own health or even to save her life. Obviously, denying her an

abortion at that point is wholly irrelevant to the prior decision "whether or not to beget or bear a child," U.S. Brief at 22 (quoting *Carey v. Population Serv. Int'l*, 431 U.S. 678, 685 (1977)), which the government asserts should be the only "liberty interest" at stake. But, this Court already has held that the state cannot insist that there be a "trade-off" between the life of the mother and the survival of the fetus. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768 (1986), *Colautti v. Franklin*, 439 U.S. 379, 400 (1979).[30]

It is difficult to accept that the government believes that serious threats to a woman's health or even her life are not relevant in assessing the balance between the woman's right and the state's interests. The manifest shortsightedness of the government's reasoning undermines completely its proposed approach. In our view, it would be inconsistent with any reasonable notion of a "narrowly tailored" statute to hold that, in order to protect its interest in potential life, a state may, regardless of circumstances and irrespective of the severity of the threat to the woman's life or health, flatly prohibit all women from choosing, in consultation with their physicians, to have an abortion performed.

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[30] The direct one-to-one trade-off is what distinguishes this case from *Jacobson v. Massachusetts*, 197 U.S. 11 (1905). It is one thing to hold that the state can compel an individual to face a limited health risk in order to protect a significant number of other individuals and where even the specific individual's health is placed at significant risk if he or she is allowed to "opt out." It is fundamentally different to say that society can impose a direct and immediate burden and risk on one individual in order to benefit another.

II. SECTIONS 188.029 AND 188.205 OF THE MISSOURI STATUTE UNCONSTITUTIONALLY INFRINGE THE FUNDAMENTAL RIGHT OF PATIENTS TO MAKE MEDICAL DECISIONS IN CONSULTATION WITH THEIR PHYSICIANS.

Given the fundamental nature of the woman's right in being able to decide whether to terminate a pregnancy, there are two types of state action which trigger heightened judicial scrutiny. First, heightened scrutiny is required when state laws interfere with the *woman's* decisions whether to enter into a physician-patient relationship with respect to abortion and whether or not to terminate her pregnancy. This Court has recognized specific situations when the compelling interest test should be applied: when a state abortion law imposes certain additional health risks on the woman; when a state law attempts to influence the woman's informed choice between abortion or childbirth through the physician-patient relationship; or when a state law imposes costs on a woman unique to the abortion procedure and out of proportion to any health benefits.[31]

Second, heightened scrutiny is appropriate when state laws interfere with a *physician's* ability to enter into a physician-patient relationship, to counsel the patient and to provide medically indicated care and treatment pertaining to the patient's pregnancy termination decision. Thus, there is infringement when a state law interferes with a physician's best medical judgment or is otherwise inconsistent with the state of medical knowledge and sound

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[31] *See, e.g., Harris v. McRae*, 448 U.S. at 328 (White, J., concurring) (additional health risks); *City of Akron*, 462 U.S. at 444 (influence woman's choice); *Planned Parenthood v. Danforth*, 428 U.S. at 69 (share decision-making authority); and *City of Akron*, 462 U.S. at 435, 438, 447 (costs unique to abortion).

IN THE
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Appellants,

v.

REPRODUCTIVE HEALTH SERVICES, et al.,
Appellees.

On Appeal from the United States Court of Appeals For the Eighth Circuit

BRIEF FOR BIOETHICISTS FOR PRIVACY AS AMICUS CURIAE SUPPORTING APPELLEES

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EXHIBIT B

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Interest of Amicus

Amicus is an ad hoc group of 57 philosophers, theologians, attorneys, and physicians from 20 states and the District of Columbia who teach medical ethics to medical students and/or physicians, or who have a major professional interest in medical ethics. Although the precise beliefs and practices of the members of this group vary, as do their professional and religious backgrounds, the members believe that permitting competent adults to make important, personal medical decisions in consultation with their physician is a fundamental principle of medical ethics, and that the doctor-patient relationship deserves the constitutional protection this Court has afforded it under the right of privacy. Medical ethics, individual autonomy, and professional accountability will all be fostered by preserv-

ing the right of privacy. Compromising the right of privacy, and substituting the state as the decisionmaker in the doctor-patient relationship, would undermine principles of medical ethics and compromise principles of good patient care and good medical practice to the detriment of physicians and patients alike.

Summary of Argument

I

Missouri asks this Court to renounce a right of privacy which this Court has described as "older than the Bill of Rights." This Court has provided lawmakers with a consistent and coherent set of parameters for identifying what the right of privacy protects, especially with respect to decisions about abortion. Abandonment of the right of privacy would permit state legislatures to control personal decisions that are now made in the doctor-patient relationship. Without the protection of the right of privacy, each legislature would be free to impose its values by dictating the outcome of what are and should be personal medical care decisions.

II

A. As this Court has recognized, a woman's right to decide to terminate a pregnancy is exercised within the context of the doctor-patient relationship. The ancient tradition of safeguarding the privacy and freedom of unfettered communication between doctor and patient is embodied in ethical precepts which the law recognizes and supports. The Missouri legislation is a direct, governmental attack on this relationship, thereby jeopardizing patients' rights, and compromising physicians' ethical obligations to their patients.

B. Both legal and ethical principles require physicians to discuss health risks that are caused or exacerbated by pregnancy and information concerning possible fetal genetic

or congenital disorders. The Missouri statutes prohibit such discussions by publicly-funded physicians if they may lead to a decision to abort. Physicians' speech is censored and patients are deprived by the state of critical information on which to base decisions about pregnancy. The ethical practice of medicine is made unlawful and the health and well-being of pregnant patients is likely to be seriously jeopardized as a result. Missouri gives "any taxpayer" of the state standing to enforce its restrictions in the courts. Thus, whatever is said or done in the privacy of the doctor-patient relationship is subject to public scrutiny at any time.

C. Without the constitutional right of privacy, there would be no constitutional principle that would prevent a state from prohibiting patients from using *any* medically recognized and accepted treatments which a majority of legislature happens to disfavor. Worse, a state would be free to prevent physicians from even telling their patients about such treatment. This differs dramatically from a state's merely refusing to pay for certain treatments.

Advances in medical science have made possible new methods of treatment for a wide variety of medical conditions, often controversial, and with the potential for profound consequences for the patient. Scientific progress has increased the importance of the doctor-patient relationship, for it is only in this context that difficult personal medical decisions can be made taking into consideration all of the medical and personal consequences that may ensue. Thus there is even more reason today to uphold the constitutional protection of decisions made in the privacy of the doctor-patient relationship than when *Roe v. Wade* was decided. For these reasons the decision of the court of appeals should be affirmed.

Argument

I. THE CONSTITUTIONAL RIGHT OF PRIVACY WHICH PROTECTS THE RIGHT TO MAKE PERSONAL MEDICAL DECISIONS IS A FUNDAMENTAL RIGHT AND A CENTRAL AMERICAN VALUE WHICH IS "IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY" AND THE COURT SHOULD CONTINUE TO PROTECT IT.

In *Griswold v. Connecticut*, 381 U.S. 479 (1965), this Court, in striking down a state statute forbidding married couples from using contraceptives, stated, "We deal with a right of privacy older than the Bill of Rights--older than our political parties, older than our school system." *Id.* at 486. In explaining this fundamental constitutional right of privacy, the Court recognized that there are decisions that are so personal, so private, and that so profoundly affect the individuals who must live with the consequences, that the state has no power to interfere in those decisions, absent a compelling interest. Since *Griswold*, this Court has applied the right of privacy to protect an unmarried person's right to decide "whether to bear or beget a child," *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972), and decisions whether or not to terminate a pregnancy. *Roe v. Wade*, 410 U.S. 113 (1973).

When the State of Missouri and the United States as amicus curiae ask this Court to overrule *Roe v. Wade*, they are asking that the most private decision that can be made by any individual be removed from that affected individual and turned over to a state legislature. We respectfully submit that this Court should not take such action.

In *Griswold* this Court recognized that the private relationship between a husband and wife prevented the state from intruding on their contraceptive decisions. In *Roe* the Court recognized the privacy of the doctor-patient relationship. While *Roe* further defined a woman's right to make

reproductive decisions, it also recognized that the pregnant woman required the advice and counsel of a licensed physician. Thus, in *Roe* the Court concluded that during the first trimester "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." 410 U.S. at 163. Later the Court stated that during the first trimester "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." *Id.* at 164. The Court also pointed out that its decision "vindicates the right of the physician to administer medical treatment according to his professional judgment" up until the point that compelling state interests justify intervention. *Id.* at 165-66. Finally, the Court pointed out that the abortion decision is 'inherently, and primarily, a medical decision" for which "basic responsibility" rests with the physician. *Id.* at 166.

Thus, as *Griswold* protected the privacy of the marital relationship, *Roe* protected the privacy of the physician-patient relationship. "The right of privacy has no more conspicuous place than in the physician-patient relationship . . ." *Doe v. Bolton*, 410 U.S. 179, 219 (1973) (Douglas, J., concurring). In this relationship both the physician and the pregnant woman must agree that termination of pregnancy is appropriate in order to have this medical procedure performed. Whether abortion is an appropriate option for a *particular* patient is, by definition, a decision that must be made by the doctor and the patient in each case. It is the right to make particularized personal decisions that is at the core of *Roe* and its progeny, and it

is this right that Missouri and the United States desire to destroy.[1]

In *Doe v. Bolton*, the court found that the restrictions Georgia had placed on abortion violated both the patient's and physician's freedom. For example, Georgia's requirement that two licensed physicians must agree with a woman's personal physician's judgment that an abortion is appropriate, and that a hospital committee of at least three other doctors must concur in the abortion decision violated the privacy protection of both the doctor and patient. In the Court's words, "The woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it are substantially limited by this statutorily imposed overview." 410 U.S. at 197.

Since *Roe* this Court has reviewed a large body of legislation designed to deny patients and physicians their right to make personal and professional judgments about how best to deal with a patient's pregnancy. As even the United States concedes, "Roe and its progeny have resolved most of the central questions about the permissible scope of abortion regulation. . . ." Brief for the United States as Amicus Curiae Supporting Appellants at 21, n. 15. Through sixteen years of constitutional adjudication this Court has provided lawmakers with a consistent and

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[1] Justice Douglas, concurring in *Doe v. Bolton*, 410 U.S. at 211, described the right of privacy as "*freedom of choice in the basic decisions of one's life respecting marriage, divorce, procreation, contraception, and the education and upbringing of children.*" He also thought of it as "*freedom to care for one's health and person, [and] freedom from bodily restraint or compulsion . . .*" *Id.* at 213.

coherent set of constitutional guidelines in this area.[2] Laws that recognized and protected the physician-patient relationship have been upheld, and laws designed to weaken or destroy that decision-making unit have been struck down. Thus, in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), the Court readily upheld a general informed consent provision, even as it applied to the first trimester, because not only did it not burden the abortion decision, it enhanced the physician-patient relationship. On the other hand, the Court has struck down a provision requiring physicians to recite a "parade of horribles" because it intruded "upon the discretion of the pregnant woman's physician." *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 445 (1983). Under this statute every physician was made an agent of the state who was required to recite the state's anti-abortion message

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[2] A review of the Court's abortion decisions indicate that it has used the following "tests" in various combinations to evaluate the constitutionality of abortion statutes:

1. Has the state placed an obstacle in front of the woman or otherwise significantly burdened the pregnant woman's ability to choose or obtain an abortion?
2. Is abortion being treated differently from other similar medical or surgical procedures?
3. Does the regulation interfere with the treating physician's exercise of professional judgment?
4. Does the regulation conflict with, or is it stricter than, accepted medical and scientific norms?
5. Is the regulation designed to protect maternal health where no less intrusive or less expensive alternative will do?
6. If a postviability rule, does the regulation protect the fetus without putting the mother in jeopardy?

Annas, *Webster and the Politics of Abortion*, 19 Hastings Center Report 36 (March/April 1989), citing Glantz, "Abortion: A Decade of Decisions," in *Genetics and the Law III* 305 (A. Milunsky & G. Annas, eds. 1985).

to every patient, regardless of her individual need or desire.

A similar statute was involved in this Court's most recent case on abortion law. The Court reiterated that forcing a physician to provide prescribed information "makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 763 (1986). The Court summarized the situation aptly: "All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures--as it obviously was intended to do--the dialogue between the woman and her physician." *Id.*

The controversy that ranges over abortion is not resolvable through reason, logic, or majority vote. It is an emotional issue governed by one's background, religious upbringing, and moral beliefs. The post-*Roe* state statutes were not health or safety laws, but rather means to control physicians and their patients so that a particular legislature's philosophical position could be imposed on pregnant women and their physicians. The Court in *Roe* recognized this problem when it pointed out that there is great diversity of opinion among philosophers, theologians and scientists about when life begins. It further recognized that the judiciary is certainly in no position to resolve this issue. 410 U.S. at 159. This is equally true of legislatures. As a result, the Court concluded that "we do not agree that, by adopting one theory of life Texas may override the rights of the pregnant woman that are at stake." *Id.* at 162.

Justice Stevens, concurring in *Thornburgh*, made a similar point: "In a sense, the basic question is whether

the 'abortion decision' should be made by the individual or by the majority 'in the unrestrained imposition of its own, extraconstitutional value preferences.'" 476 U.S. at 777-78. That is also the issue posed in this case. Justice Stevens was correct in pointing out that without the safeguards in *Roe*, there is essentially no way to restrain what the state may do in imposing its value judgments on the individual:

> . . . if federal judges must allow the State to make the abortion decision, presumably the State is free to decide that a woman may *never* abort, may *sometimes* abort, or as in the People's Republic of China, must *always* abort if her family is already too large. In contrast, our cases represent a consistent view that the individual is primarily responsible for reproductive decisions, whether the state seeks to prohibit reproduction or to require it.

Id. at 778, n. 6 (emphasis in original, citations omitted).

The pre-*Roe* world to which Missouri and the United States would like us to return is a world in which the State would have essentially absolute discretion to permit or outlaw abortions. Thus, women who were pregnant as a result of rape could be required to maintain their pregnancies and be forced to go through labor and delivery with the rapist's unwanted child. Women who would become blind, paralyzed or suffer other grave injury as a result of the continuation of their pregnancy could be compelled by state legislatures to suffer such harm. Parents who, as a result of genetic counseling and testing, know that their child will be born with a genetic disease that will cause it to die a slow, painful death, could be required to carry that pregnancy to term. These examples are not based on wild speculation about what the state of the law *might* be if *Roe* were overruled--it is based on what the state of the law

actually was at the time of *Roe*. Prior to *Roe*, abortions were outlawed in a majority of states unless the *life* (not health) of the pregnant woman was jeopardized by the continuation of the pregnancy. *Roe*, 410 U.S. at 118.[3]

The abortion cases are not just about abortion, but about the very basis of what it means to be a free person in a free society.[4] If the state can make reproductive decisions on behalf of any individual, what decision is it precluded from making? If legislatures are allowed to impose without restraint value judgments that deeply and directly affect individual citizens, what is left of personal freedom? Without the right of privacy, what constitutional principle would prevent states from reimposing restrictions on contraceptive distribution and use, since unfertilized ova constitute *potential* human life? *Doe v. Bolton*, 410 U.S. at 217 (Douglas, J. concurring). Indeed, since both Missouri and the United States argue that the state should

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[3] In its brief, the United States readily admits that states have passed "inflammatory" abortion statutes since *Roe* was decided. Brief for the United States as Amicus Curiae Supporting Appellants at 21, n.15. What is remarkable is that the United States blames the existence of *Roe* for the "inflammatory" nature of these statutes, rather than legislators' hostility to the right of pregnant women and their physicians to make decisions concerning termination of pregnancy. Should *Roe* be overruled, the tendency of legislatures to pass such inflammatory statutes will continue. What will be absent is the constitutional protection from such legislative excesses.

[4] In *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977), the Court noted that the constitutional right of privacy protects an individual's "interest in independence in making certain kinds of important decisions." In that case the Court upheld a New York statute requiring physicians to report to a state agency the prescription of certain controlled substances, because under the statute "the decision to prescribe, or to use, is left entirely to the physician and the patient." *Id.* at 603.

be free to determine when life begins, a state could choose any point in time it pleases-conception, live birth, the time the ovum develops, or three years of age.[5] Since there is no scientific answer to this question, any value judgment on this point is as "rational" as any other. However, just as this Court found that "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority," *Planned Parenthood v. Danforth*, 428 U.S. at 74, it should also conclude that one's constitutional rights are not destroyed magically because of an arbitrarily state-defined point at which "life begins."

The problem with providing the state with the essentially unlimited power sought by Missouri and the United States is that the state's actions have such a potentially profound impact on the lives of citizens. It must be kept in mind that the State is attempting to impose its values on individual citizens in order to control their decisional rights. Under *Roe* no one's values are imposed on anyone else; people are free to make the decisions that they believe are best for themselves. As Justice Stevens put it,

> In the final analysis, the holding in *Roe v. Wade* presumes that it is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect upon their destiny. Arguably a very primitive society would have been protected from evil by a rule against eating apples; a majority familiar with Adam's

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[5] *See*, Brief for The New England Christian Council as Amicus Curiae at 12. Therein is described an effort to place on the ballot in Massachusetts the following referendum question: "In *Biological Terms*, when does an individual human life begin?" The choices the voters could check off included "A. Conception" "B. Viability" "C. Birth" "D. Write In - specify a different term___."

> experience might favor such a rule. But the lawmakers who placed a special premium on the protection of individual liberty have recognized that certain values are more important than the will of a transient majority.

Thornburgh, 476 U.S. at 781-82 (concurring opinion).

II. The Right Of Privacy Protects The Rights Of Individuals To Make Personal Medical Decisions In A Doctor-Patient Relationship

A. *The Doctor-Patient Relationship, not the Legislature, is the Proper Locus for Medical Care Decisions*

The central question before the Court is whether personal medical care decisions should be made by patients and their physicians, or by the state. The doctor-patient relationship is highly valued in our society.[6] The importance of the doctor-patient relationship to individual citizens increases in proportion to advances in medical science. These advances have made the consequences of many medical interventions increasingly dramatic in the lives and deaths of individual citizens and their families. The importance of who makes the treatment decision increases as the complexity of the options and the severity of the impact of treatment on the individual patient increases. *Roe* properly took full account of changing medical science. The central premise of *Roe* and *Doe*, that inherently personal medical decisions, including those

[6] Indeed, protecting the ethical integrity of the medical profession in ways consistent with the individual autonomy of patients has been deemed a "compelling state interest" by courts since *Roe v. Wade*. *E.g.*, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. den. sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

involving abortion, should be made in the context of a doctor-patient relationship protected from governmental dictates, remains sound jurisprudence.

The doctor-patient relationship has been a privileged and protected one throughout the history of Western civilization. Plato, for example, describes how in Ancient Greece slaves were treated as objects and that therefore no conversation between them and the physician occurred. The relationship between a free physician and a free citizen, by contrast, fit what it means to be a free person; that is, physicians talked to their patients:

> The free practitioner who, for the most part, attends free men, treats their disease by going into things thoroughly from the beginning in a scientific way, and takes the patient and his family into his confidence . . . He does not give his prescriptions until he has won the patient's support . . .

Laws, 4.720b-e.

The doctor-patient relationship between two free citizens that has become the cornerstone of Western medical ethics begins with an individual who determines that a condition requires medical attention. Medical attention is voluntarily sought, and the physician makes a decision as to whether or not medical care can be of benefit to the patient, and if so, recommends one or more alternatives. The doctor and patient then discuss these alternatives. Together they decide what course of action to pursue based on their perceptions of benefit in a private, confidential relationship which ethical principles of

autonomy, beneficence and justice have structured and the law has fostered and protected.[7]

The decision to continue or terminate a pregnancy is just one example albeit a dramatic one, of important, personal medical decisions made in this relationship. To insure that a mutually-acceptable decision is arrived at with full understanding, the common law has required physicians to share information with their patients under the doctrine of "informed consent."[8] Law and ethics, therefore, have now effectively merged. As the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded,

> Although the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative. . . . Ethically valid consent is a process of shared decisionmaking based upon mutual respect and participation . . . adults are entitled to accept or reject health care interventions on the basis of their own personal values in furtherance of their own personal goals.

Making Health Care Decisions 2-3 (1982).

B. *States Should Not be Permitted to Dictate or Censor the Content of Discussions that Occur in a Doctor-Patient Relationship*

It is in the informed consent context, and its respect both for the rights of individual patients and the integrity

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[7] *See, e.g.*, Ad Hoc Committee on Medical Ethics, American College of Physicians, *American College of Physicians Ethics Manual*, Part I, 101 Annals of Internal Medicine 129, 130 (1984).

[8] Legal action to remedy instances of nondisclosure developed where the Platonic ideal was not being followed and physicians were withholding important information from their patients. R. Faden & T. Beauchamp, *A History and Theory of Informed Consent* (1986).

of the medical profession, that *Roe's* placement of the abortion decision with "the woman and her physician" is properly understood. Neither party has total or arbitrary power, but both must agree and consider the decision appropriate and reasonable before it can be acted on. *Roe* properly assumed that "states would subject the woman's wishes to interpersonal testing within a clinical relationship, by treating abortion as a medical procedure . . . A medical decision, at its best, is made between a patient and a doctor who acts pursuant to professional values, ones developed out of clinical encounters and subjected to peer criticism within a regimen of professional education, research, and ethical study." R. Goldstein, *Mother-Love and Abortion: A Legal Interpretation* 81 (1988); *see also* A. Jonsen, M. Siegler & W. Winslade, *Clinical Ethics* 62 (2d ed. 1986).

Of course, such an interpersonal dialogue can only take place in an atmosphere in which the physician is free to exercise his or her best professional judgment and discuss with a patient all of the information, including treatment options, relevant to the patient's decision. Section 188.205 of the Missouri statute before this Court, however, would prohibit such dialogue. That section makes it "unlawful for any public funds to be expended . . . for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life." The term "encourage or counsel" is so vague that reasonable people would be unable to distinguish between lawful and unlawful behavior. It does not merely prohibit coercing a woman to have an abortion. Rather, the state uses words that describe the personal discussions between a woman and her physician about the management of her pregnancy. Other

courts have agreed that this language prohibits physicians from talking to their patients.[9]

In section 188.210, Missouri attempted to make it "unlawful" for a publicly-employed physician or other health care personnel to "counsel or encourage a woman to have an abortion not necessary to save her life." In this appeal, Missouri has abandoned any defense of this direct prohibition against counseling of patients by physicians. Instead Missouri seeks to achieve the same result by a different means in section 188.205. This section certainly prohibits any publicly-employed physician from counseling or encouraging abortions because it is unlawful to expend public funds for that purpose, and the physician's salary is derived from state funds. Thus, its impact is identical with the second sentence of section 188.210. In fact this section has an even wider impact than 188.210 because it applies not just to public employees, but to anyone who receives state funds.

The statute both silences physicians and forces patients to remain ignorant, erecting a state-created barrier between a woman and her physician. Under the stature [sic], for example, a physician, public or private, who receives state funds would be unable to honestly respond to a pregnant

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[9] Two federal district courts found that the Department of Health and Human Services regulations prohibiting family planning programs funded under Title X from counseling or referring for abortion, 53 Fed. Reg. 2922 (Feb. 2, 1988), violated the First Amendment rights of the programs and enjoined their enforcement. *Massachusetts v. Bowen*, 679 F. Supp. 137 (D. Mass. 1988), appeal docketed, No. 88-1279 (1st Cir. Mar. 24, 1988); *Planned Parenthood Federation v. Bowen*, 680 F. Supp. 1465 (D. Colo. 1988). A third district court agreed that the prohibition forbade speech but concluded (erroneously we believe) that granting Title X funds to support one idea and not another did not infringe free speech. *State of New York v. Bowen*, 690 F. Supp. 1261 (S.D.N.Y. 1988), *aff'd.*, 863 F.2d 46 (2d Cir. 1988).

woman whose health is endangered by the pregnancy when she asks, "Doctor, what do you think I should do?", if the honest answer were, "I would recommend you have an abortion."[10]

Prohibiting physicians who receive state funds from "encouraging or counseling" pregnant women consistent with their best medical judgment is contrary to good medical practice and jeopardizes patients' rights. Information concerning health risks that are caused or exacerbated by pregnancy and information concerning possible fetal genetic or congenital disorders are squarely among the categories of information that a physician is obligated by law and ethics to disclose to a pregnant woman in order to facilitate knowledgeable decisions about managing her pregnancy.[11] It is good and accepted medical practice to

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[10] An analogous "gag rule" is apparently in effect in the Soviet Union in the area surrounding Chernobyl where it is reported that government authorities assure everyone that all is normal, "and then advise villagers not to bear children or each locally grown mushrooms." When the villagers take their children to special government clinics in Kiev for regular medical tests, "the doctors refuse to disclose the results." Gumbel, *Villagers Suffering Chernobyl's Fallout Face Soviet Silence*, Wall Street J., March 6, 1989, at 1, col. 4.

[11] The Federal Food and Drug Administration itself requires manufacturers of intrauterine devices to inform physicians that if a woman becomes pregnant with an I.U.D. in place, and removal of the I.U.D. is difficult, "termination of the pregnancy should be considered and offered the patient as an option..." 21 C.F.R. 310.502(b)(1). The physician's counseling obligation includes informing parents of the availability of prenatal diagnosis of genetic abnormalities. *E.g., Goldberg v. Ruskin*, 128 Ill. App. 3d 1029, 471 N.E.2d 530 (1984), *aff'd*, 113 Ill. 2d 482, 499 N.E. 2d 406 (1986) (failure to advise parents of tests designed to detect Tay-Sachs disease). Physicians also have an obligation to diagnose abnormalities with due care and disclose their findings. *E.g., Smith v. Cote*, 128 N.H. 231, 513 A.2d 341

inquire into the genetic and medical history of a prospective mother and father who consult any physician for advice or care concerning family planning, contraception, and pregnancy evaluation. *See* American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 18-19 (5th ed. 1985); S. Elias and G.J. Annas, *Reproductive Genetics and the Law* (1987); President's Commission for the Study of Ethical Problems in Medicine, *Screening and Counseling for Genetic Conditions* 23-31 (1983).

By attempting to silence certain physicians, Missouri seeks to prevent them from performing their ethical and legal obligations to their patients consistent with existing medical science, and thereby deprive patients of information they need in order to decide whether to have a child. In this regard the state of Missouri promotes ignorance, viewing an uninformed patient as a desirable result. There are medical conditions for which abortion is one of the reasonable medical procedures that should be discussed. For example, Tay-Sachs disease is a genetic disorder that occurs in one in four pregnancies when both husband and wife are carriers of the gene. The disease "is characterized by motor weakness, usually beginning between 3 and 6 months of age. . . deafness, blindness, convulsions, and generalized spasticity are usually in evidence by 18 months of age . . . the child develops a state of decerebrate rigidity, with death usually resulting . . . by 3 years of

(1986) (failure to timely diagnose rubella and inform parents of consequences). So strongly have courts insisted on counseling, that they have held physicians liable for failing to offer information which might lead a patient to consider abortion even when abortion was statutorily proscribed in most states. *See e.g., Jacobs v. Theimer*, 519 S.W.2d 846 (Tex. 1975) (physician's failure to diagnose rubella in pregnant woman in 1958 and to advise her of risks to fetus held actionable wrong even though abortion was illegal in Texas).

age. No specific therapy for Tay-Sachs disease is available." S. Elias & G. Annas, *Reproductive Genetics and the Law* 63 (1987) and sources cited therein. Since abortion is the *only* way to prevent this tragedy, a physician who informs a couple of the existence of prenatal testing to detect it, and discusses the option of abortion with them would be violating the proscription against "counseling or encouraging" abortion. Without the option of prenatal screening, many at risk couples would simply choose to abort all pregnancies. "In fact, since more than 95% of all prenatal diagnostic tests are negative, the overwhelming majority of such testing helps lead to the birth of children that might not otherwise have been born." *Id.* at 83. Thus the irony is that any law that inhibits physicians from counseling pregnant women about the availability of genetic testing and the option of abortion may actually increase the number of abortions performed.

Since section 188.210 prohibits publicly-employed physicians from *performing* abortions, it is essential that they be permitted to refer a patient in need of abortion to a physician who is willing and able to do so. Yet, such a medically appropriate referral would violate the proscription against encouraging and counseling, since abortion is a probable outcome of the referral. At the same time, failure to refer the patient to the second physician would be negligent medical practice which could harm the patient.[12]

[12] *See, e.g., Jewson v. Mayo Clinic*, 691 F.2d 405 (8th Cir. 1982). If a physician determines, in the exercise of sound clinical judgment, that the pregnancy poses a threat to the health or well-being of his patient, he is not excused from disclosing that judgment simply because he may be unable to perform an abortion. If he is unwilling or unable to perform an abortion that he believes is medically indicated, he must also disclose that fact to the patient. *Manion v. Tweedy*, 257 Minn. 59, 100 N.W.2d 124, 128 (1959). In addition, the physician must immediately refer the patient to an appropriate provider, because

The fact that the physicians currently targeted by the Missouri statute are paid with state funds does not lessen either the extent of the invasion or the obligation such physicians have to counsel their patients.[13] Government-employed physicians who were not expected or obliged to render ongoing care to individuals have been found to owe a duty of disclosure to persons they examine. For example, in *Betesh v. United States*, 400 F. Supp. 238 (D.D.C. 1974), a selective service physician was found liable for failing to disclose a chest abnormality in a recruit during a pre-induction physical. The recruit later died of Hodgkins disease, which might have been successfully treated had treatment begun when the abnormality was first discovered. Even in the absence of a consensual doctor-patient relationship, concealment of the information was actionable, the court found, because "the Government physicians were under a duty to act carefully, not merely in the conduct of the examination, but also in subsequent communications to the examinee." *Id.* at 246. Thus, the legal and ethical obligation to counsel does not depend upon the nature of the physician's employer or source of payment.

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delay could cause harm and make further treatment, including later termination of pregnancy, more risky and harmful. *See, e.g., Steele v. United States*, 463 F. Supp. 321, 330 (D. Alaska 1977); *Wells v. Billars*, 391 N.W.2d 668 (S.D. 1986).

[13] The source of payment does not excuse a physician from fulfilling his obligations to his patient. As the California Appeals Court said in *Wickline v. California*, 192 Cal. App. 3d 1630, 1645, 228 Cal. Rptr. 661 (1986), *app. dism'd*, 239 Cal. Rptr. 805, 741 P.2d 613 (1987): "[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."

The Missouri legislation not only interferes with honesty on the party of the physician, it does so in the most intrusive fashion, sundering the curtain of privacy from the physician-patient relationship. Not only does the state claim the right to control what doctors say to patients, it encourages strangers to police what is said. Section 188.220 of the Missouri statute grants standing to "any taxpayer of [the] state" to enforce the provisions which prohibit encouraging or counseling a woman to have an abortion. Thus, perfect strangers are given the power of private attorneys general to scrutinize the highly personal information discussed in a physician's office. The statute can only be enforced by requiring physicians and their patients to publicly disclose the content of their discussions held in the privacy of the doctor-patient relationship. Having strangers invade this relationship is every bit as offensive and chilling as permitting "police to search the sacred precincts . . . of marital bedrooms." *Griswold v. Connecticut*, 381 U.S. at 485.[14]

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[14] A recent New York case underscores the inappropriateness of encouraging strangers to intervene in these private decisions. The case, *In the Matter of Martin Klein*, Supreme Ct. of New York, Nassau Cty. No. 1736/89 (Feb. 7, 1989), involved a 32-year-old woman who was 17 weeks pregnant, and comatose as a result of an automobile accident. Her husband was advised by her physician that continuation of her pregnancy presented a serious threat to her life, and that termination of the pregnancy was indicated. He then petitioned the court for an order that he be appointed his wife's temporary guardian for the purpose of authorizing her physician to perform such medical procedures, including abortion, as may be necessary to preserve her life. Two total strangers with an anti-abortion agenda petitioned the court requesting to be made the guardian of the woman and the non-viable fetus, in an attempt to exclude the patient's husband and parents from making these decisions. Both trial court and Appellate Division decided for the husband. As the Appellate Division stated, "these absolute strangers to the Klein family, whatever their motivations, have no place in the

C. *Overruling the Constitutional Right of Privacy Would Seriously Undermine Individual Autonomy and Would Permit the State To Make Medical Care Decisions That Belong to Individuals*

A consistent series of decisions since *Roe v. Wade* permit individuals to refuse various medical interventions. Many of these decisions are based in part on the constitutional right of privacy which enables individuals to make important personal medical decisions for themselves. In a widely cited case, for example, the New Jersey Supreme Court decided that, were she competent, Karen Ann Quinlan, a young woman in a permanent coma, would have the authority under the constitutional right of privacy to decide to have the mechanical ventilator that sustained her life removed. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 663 (1976), *cert. den. sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). Since she was incompetent, the court ruled that her parents could act in her behalf. In *Quinlan*, as in many similar cases decided since, the state argued that it, not the patient, should make the decision whether or not to employ an intrusive, and often futile, medical intervention.

Without the shield of the constitutional right of privacy, citizens would have no protection from such state interventions in private medical matters, because states would be free to legislate virtually any restrictions on individual treatment decisions that even a bare majority of legislators wished. This is particularly important today when new forms of medical treatment and knowledge require patients to make controversial choices. Since 1973, physicians have learned to fertilize human eggs in a petri

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midst of this family tragedy." *Matter of Nancy Klein*, New York Appellate Division, Second Department, New York Law Journal, Feb. 14, 1989, at 21.

dish and transfer the resulting embryo to the wife for gestation; to accurately detect severe fetal handicaps such as anencephaly and neural tube defects; and to maintain patients who cannot breathe on their own in a permanent coma for months and even years.

It would not be far-fetched to hypothesize a state that would choose to outlaw the use of *all* prenatal diagnostic techniques by both public and private physicians. Legislators may feel that such tests lead couples either not to have children or to abort their pregnancies. Without the protection of the constitutional right of privacy, state legislatures would be empowered to control the knowledge and use of such medical techniques, and require couples to make their child-bearing decisions in ignorance.[15] What would prohibit states from outlawing new and "unnatural" means of conceiving a child such as *in vitro* fertilization techniques? What would prohibit states from requiring that *every* medical intervention must be used to keep a dying person alive as long a biologically possible, regardless of the desires of the patient or family, and no matter that the patient's physician agrees that this would not be good medical practice? No constitutional principle, other than the right of privacy, would protect these decisions, and others like them, from being made for patients by the state. Unfettered by the constitutional right of privacy, states

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[15] Prohibitions against *payment* for treatment should not be confused with prohibitions against providing *information* about treatment. For example, the state of New Hampshire has the right not to pay for bone marrow transplants, as evidenced by its initial decision in the case of a six-year-old boy in February 1989. Hohler, *State Policy, Human Tragedy*, Boston Globe, Feb. 26, 1989, at 1. It would be astonishing, however, to even suggest that New Hampshire should be able to forbid the boy's physician, even if the physician were a state employee, from telling him that he needed a transplant and could get it elsewhere. Yet this is what Missouri claims it may do.

would have virtually unlimited power both to prohibit citizens from obtaining basic medical care from their physicians, and to require them to undergo medical procedures against their will.

We have already witnessed examples of how state power can be misused in a way that increases the suffering of its citizens when the right to make personal medical decisions is not treated as a fundamental constitutional right. In one example, a competent pregnant woman who was dying of cancer was forced to endure a cesarean section against her will, and that of her family and physicians, by a judge who thought that the state's interest in potential fetal life outweighed any interest she might have in refusing surgical intervention. *In re A.C.*, 533 A.2d 611 (App. D.C. 1987), *vacated* 539 A.2d 203 (App. D.C. 1988).[16] After the forced surgery--which was, in

[16] There are at least twenty-one orders by lower court judges that have required competent adult women to undergo cesarean section operations (a major surgical procedure which is substantially more life-threatening than abortion) instead of the normal delivery that they wished to have. Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192 (1987). These orders were based on the notion that the state, through its judges, has a greater interest in the potential life of the fetus and the method of childbirth than the woman herself, and demeaned and dehumanized the pregnant woman by denying her the right to voluntarily choose the method of childbirth. Continued discussion with her physician, rather than hasty resort to emergency decisions by judges, is properly encouraged by recognizing the right to privacy in the doctor-patient relationship. Indeed, "By protecting the liberty of the pregnant patient and the integrity of the voluntary doctor-patient relationship, we not only promote autonomy; we also promote the well-being of the vast majority of fetuses." Annas, *Protecting the Liberty of Pregnant Patients*, 316 New Eng. J. Med. 1213, 1214 (1987). *And see* T. Engelhardt, *The Foundations of Bioethics* 224-27 (1985); and Nelson & Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 J.A.M.A. 1060 (1988).

effect, a forced abortion of a non-viable fetus--both mother and child died.

In a second example, with facts virtually identical to those in *Quinlan*, a Missouri trial court found that it had sufficient evidence, based on the patient's prior statements and her family's testimony, that the patient would not wish to receive treatment if she were in a permanent coma, and ruled that treatment should therefore be stopped in accordance with her "constitutionally guaranteed liberty." *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988). The Missouri Supreme Court overruled the trial court's finding and, disregarding the patient's previous statements and her parent's wishes, turned over her medical treatment decisions to employees of the state. This means that for the rest of her life the people who know and love her most are relegated to the role of passive observers. *See*, generally, Annas, *The Insane Root Takes Reason Prisoner*, 19 Hastings Center Report 29 (Jan./Feb. 1989). The Missouri Supreme Court's decision was based in part on its reading of the preamble of the abortion statute at issue in this case.

These examples demonstrate that state interference is not hypothetical. State medical treatment decisions are at best arbitrary and impersonal, and at worst cruelly at odds with a patient's wishes and well-being. This leads inexorably to the conclusion that personal medical decisions should be made by those who are most affected by them, in the context of a constitutionally-protected doctor-patient relationship.[17]

[17] Unlike the Missouri Supreme Court, in the vast majority of cases decided since *Roe*, courts have recognized that the constitutional right of privacy places control of personal medical decisions in the hands of patients or their guardians if the patient is incompetent. For example, courts have upheld the patient's right to decide whether to

If the state is given absolute control of a decision as personal and private as the decision whether or not to continue a pregnancy, based on its interest in "potential human life," then it could certainly control these other decisions. If this Court adopts such a statist notion of decisionmaking then the value of "personhood" will have been significantly demeaned for all citizens. Having control over these most important and private decisions is an essential element not only of freedom, but of being a person. As the Massachusetts Supreme Judicial Court put it: "The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life." *Saikewicz*, 370 N.E.2d at 426.

Missouri does not claim that its power is limited to prohibiting abortion. Their sole interest is in protecting *potential* life, rather than *existing* human life. What is most remarkable about virtually all of the briefs submitted to this Court on behalf of Missouri is that they imply that the United States is composed exclusively of state governments and fetuses; women and their physicians are treated as almost irrelevant, and the relationship between a pregnant woman and her physician is ignored.

Missouri seeks to reintroduce the Platonic ideal in a particularly pernicious manner: men are to be treated as "free citizens"; women are to be treated in a manner

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accept or reject medical treatments such as surgery for breast cancer, *In re Yetter*, Northampton Co. Orphans Ct., No. 1973-533 (Williams, Jr.) (Pa. 1973); amputation, *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. 1978); kidney dialysis, *In the Matter of Spring*, 389 Mass. 629, 405 N.E.2d 115 (1980); respirators, *Satz v. Perlmutter*, 362 So.2d 160 (Fla. App. 1978), *aff'd*. 379 So.2d 359 (Fla. 1980); and artificial nutrition and hydration, *In the Matter of Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

similar to the way "slaves" were treated by free physicians in ancient Greece: conversation is to be censored and treatment decisions made without regard for the wishes of the patient. Such a situation is incompatible with both liberty and equal protection. As this Court has properly emphasized: "Our cases long have recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government . . . That promise extends to women as well as to men." *Thornburgh*, 476 U.S. at 772 (1986).

Conclusion

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	NO. C94-119
Plaintiffs,	PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT
vs.	NOTE ON MOTION CALENDAR FEBRUARY 25, 1994
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	ORAL ARGUMENT REQUESTED
Defendants.	

Pursuant to Federal Rule of Civil Procedure 56 and CR 7 of the Rules of the United States District Court for the Western District of Washington, plaintiffs move for summary judgment. The reasons for granting plaintiffs' motion are set forth in Memorandum in Support of Plaintiffs' Motion for Summary Judgment, submitted herewith.

DATED: February 3, 1994.

PERKINS COIE
Thomas L. Boeder
David J. Burman

By /s/
Kathryn L. Tucker
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	ANSWER TO COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

COME NOW the defendants in the above entitled cause, the State of Washington and Christine Gregoire, Attorney General of Washington, by and through their attorneys, Christine Gregoire, Attorney General, and William L. Williams, Senior Assistant Attorney General, and answer the complaint of the plaintiffs as follows:

1. In answer to paragraphs 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7 and 2.8 of the plaintiffs' complaint, defendants are without knowledge sufficient to form a belief as to the truth of the allegations contained therein and therefore, neither admit nor deny those allegations, leaving plaintiffs to their proof.

2. Defendants admit the allegations contained in paragraph 2.9 of the plaintiffs' complaint.

3. Answering paragraph 2.10 of plaintiffs' complaint, defendants admit that the Attorney General is the chief legal officer of the State of Washington. Defendants affirmatively allege that the Office of the Attorney General was established in Article 3, § 21 of the Constitution of the State of Washington and further that the powers of the Attorney General are set forth in statute, primarily RCW 43.10. Defendants admit that the Attorney General is a proper party defendant to this lawsuit, but deny that she serves in any representative capacity with respect to other law enforcement officers in the state.

4. Paragraphs 1.1, 1.2 and 2.11 of the complaint appear to be assertions of legal theory and not factual allegations and therefore require no answer. To the extent an answer is required, defendants admit that 42 USC § 1983 may be a basis for a suit alleging violation of Fourteenth Amendment rights, but deny that the existence or operation of RCW 9A.36.060 violates, or threatens a violation of, any rights of any plaintiff; defendants admit

the second sentence of paragraph 1.1, and paragraphs 1.2 and 2.11.

5. Defendants deny the allegations contained in paragraphs 3.1, 3.2, and 3.3 of the plaintiffs' complaint.

6. In answer to paragraph 3.4 of the plaintiffs' complaint, defendants are without knowledge sufficient to form a belief as to the truth of the allegations contained therein and therefore, neither admit nor deny those allegations, leaving plaintiffs to their proof.

Defendants allege by way of affirmative defense that plaintiffs have failed to state a claim upon which relief can be granted.

WHEREFORE, having fully answered the complaint of the plaintiffs and having stated an affirmative defense, defendants request that judgment be entered as follows:

1. Dismissing the plaintiffs' complaint;

2. Awarding defendants costs and attorney's fees; and

3. Awarding defendants any additional or further relief which the court finds appropriate or just.

DATED this 11th day of February, 1994.

CHRISTINE GREGOIRE
Attorney General

/s/
William L. Williams
Assistant Attorney General
Attorney for Defendants

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report I-93-8

Subject: Physician Assisted Suicide
(Resolution 3. A-93--Medical Student Section)

Presented by: John Glasson, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Louis R. Zako, MD, Chair)

Introduction*

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has long-standing policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report. "Decisions Near the End of Life."[1] In that report, the Council concluded that physician assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not . . . participate in assisted suicide."[1] Previously, the Council had issued reports rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia--is contrary to

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* In accordance with the Joint Report of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws (I-91), this report may be adopted, not adopted, or referred. It may only be amended, with the concurrence of the Council, to clarify its meaning.

public policy, medical tradition, and the most fundamental measures of human value and worth."[2] Similarly in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.'"[3]

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins (NY Times, June 6, 1990:A1). The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull.[4] Other public events quickly followed. Physician assisted suicide, together with euthanasia, was placed on the public ballot in Washington State, in November 1991, and in California in November 1992. Both times, voters turned down proposals to legalize physician assisted dying (USA Today, August 9, 1993:13A). In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide (NY Times, October 1, 1993:A8). In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician assisted suicide.

Definitions

Assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician assisted suicide, the patient performs the life-ending act, whereas in euthanasia, the physician administers the death-causing drug or other agent.[5]

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.[1]

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.[1]

Ethical Considerations

1. Inappropriate extension of the right to refuse treatment. In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."[1]

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-

determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.[6(p.121)]

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible.[7] The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of life-sustaining treatment, society does not limit the right to

refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.[8]

2. <u>The physician's role</u>. The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain.[9] Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled.[10,11] Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of

physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary to fully relieve the patient's pain.[9] The patient's treatment plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decision maker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients, and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression.[1]

Relieving the patient's psychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal psychological and spiritual support of family and friends."[12] Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention.[13] Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/or anti-depressant medications. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued.[14,15,16] Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can

go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation and other comfort care for the associated discomfort.

3. "Slippery slope" concerns. Permitting assisted suicide opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives, but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands,[17] however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision-maker since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

Recommendations

1. Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.

4. Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

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Council Report

Decisions Near the End of Life [*][**]

Council on Ethical and Judicial Affairs
American Medical Association

OVER the last 50 years, people have become increasingly concerned that the dying process is too often needlessly protracted by medical technology and is consequently marked by incapacitation, intolerable pain, and indignity. In one public opinion poll, 68% of respondents believed that "people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course."[1] A number of comparable surveys indicate similar public sentiment.[2]

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* From the Council on Ethical and Judicial Affairs American Medical Association, Chicago, Ill.

This report is an abridged version of Report B adopted by the House of Delegates of the American Medical Association at the 1991 Annual Meeting.

Reprint requests to the Council on Ethical and Judicial Affairs, American Medical Association, 515 N State St, Chicago, IL 60610 (David Orentlicher, MD, JD).

** Members of the Council on Ethical and Judicial Affairs include the following: Richard J. McMurray, MD, Flint, Mich, Chair; Oscar W. Clarke, MD, Gallipolis, Ohio, Vice Chair; John A. Barrasso, MD, Casper, Wyo; Dexanne B. Clohan, Arlington, Va; Charles H. Epps, Jr., MD, Washington, DC; John Glasson, MD, Durham, NC; Robert McQuillan, MD, Kansas City, MO; Charles W. Plows, MD, Anaheim, Calif; Michael A. Puzak, MD, Arlington, Va; David Orentlicher, MD, JD, Chicago, Ill, Secretary and staff author; Kristen A. Haikola, Chicago, Ill, Associate Secretary and staff author; and Anita K. Schweickart, Chicago, Ill, Staff Associate and principal staff author.

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Decisions Near the End of Life–Council on Ethical and Judicial Affairs
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Since the turn of the century, there has been a dramatic shift in the places where people die. Sixty years ago, the vast majority of deaths occurred at home. Now most people die in hospitals or long-term care facilities. Approximately 75% of all deaths in 1987 occurred in hospitals and long-term care institutions,[3] up from 50% in 1949, 61% in 1958, and 70% in 1977.[4] This transition from the privacy of the home to medical institutions has increased public awareness and concern about medical decisions near the end of life. "Since deaths which occur in institutions are more subject to scrutiny and official review, decisions for death made there are more likely to enter public consciousness."[5]

The development of sophisticated life support technologies now enables medicine to intervene and forestall death for most patients. Do-not-resuscitate orders are now commonplace.[6] The Office of Technology Assessment Task Force estimated in 1988 that 3775 to 6575 persons were dependent on mechanical ventilation and 1404 500 persons were receiving artificial nutritional support.[7] This growing capability to forestall death has contributed to the increased attention to medical decisions near the end of life.[5]

The Council has issued opinions on withdrawing and withholding life-prolonging treatment from patients who are terminally ill or permanently unconscious and has also published reports concerning do-not-resuscitate orders,[9,10] euthanasia,[11] and withdrawal of life--prolonging treatment from permanently unconscious patients.[12] This report will re-examine the Council's existing positions and will expand the analysis to include physician-assisted suicide and withdrawing or withholding life-sustaining treatment for patients who are neither terminally ill nor permanently unconscious. The report will focus on competent patients in nonemergency situations. The issue of decisions near

the end of life for incompetent patients is addressed in a separate report by the Council.[13]

DEFINITIONS

The decisions near the end of life examined in this report are those decisions regarding actions or intentional omissions by physicians that will foreseeably result in the deaths of patients. In particular, these decisions concern the withholding or withdrawing of life-sustaining treatment, the provision of a palliative treatment that may have fatal side effects, euthanasia, and assisted suicide.

Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. At one time, the term *passive euthanasia* was commonly used to describe withholding or withdrawing life-sustaining treatment. However, many experts now refrain from using the term passive euthanasia.

The provision of a palliative treatment that may have fatal side effects is also described as *double-effect euthanasia*. The intent of the treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a foreseeable potential effect of the treatment. An example is gradually increasing the morphine dosage for a patient to relieve severe cancer pain, realizing that large enough doses of morphine may depress respiration and cause death.

Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy. In this report, the term euthanasia will signify the medical administration of a lethal agent to a patient for the purpose

of relieving the patient's intolerable and incurable suffering.

Voluntary euthanasia is euthanasia that is provided to a competent person on his or her informed request. *Nonvoluntary euthanasia* is the provision of euthanasia to an incompetent person according to a surrogate's decision. *Involuntary euthanasia* is euthanasia performed without a competent person's consent. This report will not examine involuntary euthanasia further, since it clearly would never be ethically acceptable.

Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life-ending action (eg, administering a lethal injection). *Assisted suicide* occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

Discussions about life-ending acts by physicians often refer to the patient's "competence" or "decision-making capacity." The two terms are often used interchangeably. However, *competence* can also refer to a legal standard regarding a person's soundness of mind. *Decision-making capacity* signifies the ability to make a particular decision and is not considered a legal standard. "Competence" for the Council's purposes will mean "decision-making capacity."

The evaluation of a person's decision-making capacity is an assessment of the person's capabilities for understanding, communicating, and reasoning. Patients should not be judged as lacking decision-making capacity based on the view that what they decide is unreasonable." People are entitled to make decisions that others think are foolish

as long as their choices are arrived at through a competently reasoned process and are consistent with their personal values.

ETHICAL FRAMEWORK

Determining the ethical responsibilities of physicians when patients wish to die requires a close examination of the physician's role in society. Physicians are healers of disease and injury, preservers of life, and relievers of suffering. Ethical judgments become complicated, however, when these duties conflict. The four instances in which physicians might act to hasten death or refrain from prolonging life involve conflicts between the duty to relieve suffering and the duty to preserve life.

The considerations that must be weighed in each case are: (1) the principle of patient autonomy and the corresponding obligation of physicians to respect patients' choices; (2) whether what is offered by the physician is sound medical treatment; and (3) the potential consequences of a policy that permits physicians to act in a way that will foreseeably result in patients' deaths.

Patient Autonomy

The principle of patient autonomy requires that competent patients have the opportunity to choose among medically indicated treatments and to refuse any unwanted treatment. Absent countervailing obligations, physicians must respect patients' decisions. Treatment decisions often involve personal value judgments and preferences in addition to objective medical considerations. We demonstrate respect for human dignity when we acknowledge "the freedom [of individuals] to make choices in accordance with their own values."[15]

Sound Medical Treatment

The physician's obligation to respect a patient's decision does not require a physician to provide a treatment that is not medically sound. Indeed, physicians are ethically prohibited from offering or providing unsound treatments. Sound medical treatment is defined as the use of medical knowledge or means to cure or prevent a medical disorder, preserve life, or relieve distressing symptoms.

This criterion of soundness arises from the medical ethical principles of beneficence and nonmaleficence. The principle of *nonmaleficence* prohibits physicians from using their medical knowledge or skills to do harm, on balance, to their patients, while the principle of *beneficence* requires that medical knowledge and skills be used to benefit patients.

Generally, a treatment that is likely to cause the death of a patient violates the principle of nonmaleficence, and a failure to save a patient's life is contrary to beneficence. However, for these decisions near the end of life the patient does not consider his or her death to be an absolutely undesirable outcome.

Practical Considerations

Policies governing decisions near the end of life must also be evaluated in terms of their practical consequences. The ethical acceptability of a policy depends on the benefits and costs that result from the policy. In addition to the impact on individual cases (eg, patients will die according to their decision to have life supports withdrawn), there are likely to be serious societal consequences of policies regarding physicians' responsibilities to dying patients.

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is the patient's death.[4] The right of competent patients to forgo life-sustaining treatment has been upheld in the courts (for example, *In re Brooks Estate,* 32 Ill2d 361, 205 NE2d 435 [1965]; *In re Osborne,* 294 A2d 372 [1972]) and is generally accepted by medical ethicists.[4]

Decisions that so profoundly affect a patient's well-being cannot be made independent of a patient's subjective preferences and values.[16] Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death.[7] When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would likely be painful, nauseating, and debilitating. Similarly, when a patient is dying, there may be a choice between returning home to a natural death, or remaining in the hospital, attached to machinery, where the patient's life might be prolonged a few more days or weeks. In both cases, individuals might weigh differently the value of additional life vs the burden of additional treatment.

The withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence. The physician is obligated only to offer sound medical treatment and to refrain from providing treatments that are detrimental, on balance, to the patient's well-being. When a physician withholds or withdraws a treatment on the request of a

patient, he or she has fulfilled the obligation to offer sound treatment to the patient. The obligation to offer treatment does not include an obligation to impose treatment on an unwilling patient. In addition, the physician is not providing a harmful treatment. Withdrawing or withholding is not a treatment, but the forgoing of a treatment.

Some commentators argue that if a physician has a strong moral objection to withdrawing or withholding life-sustaining treatment, the physician may transfer the patient to another physician who is willing to comply with the patient's wishes.[4] It is true that a physician does not have to provide a treatment, such as an abortion, that is contrary to his or her moral values. However, if a physician objects to withholding or withdrawing the treatment and forces unwanted treatment on a patient, the patient's autonomy will be inappropriately violated even if it will take only a short time for the patient to be transferred to another physician.

Withdrawing or withholding some life-sustaining treatments may seem less acceptable than others. The distinction between "ordinary" vs "extraordinary" treatments has been used to differentiate ethically obligatory vs ethically optional treatments.[17] In other words, ordinary treatments must be provided, while extraordinary treatment may be withheld or withdrawn. Varying criteria have been proposed to distinguish ordinary from extraordinary treatment. Such criteria include customariness, naturalness, complexity, expense, invasiveness, and balance of likely benefits vs burdens of the particular treatment.[17,18] The ethical significance of all these criteria essentially are subsumed by the last criterion--the balance of likely benefits vs the burdens of the treatment.[17]

When a patient is competent, this balancing must ultimately be made by the patient. As stated earlier, the evaluation of whether life-sustaining treatment should be initiated, maintained, or forgone depends on the values and preferences of the patient. Therefore, treatments are not objectively ordinary or extraordinary. For example, artificial nutrition and hydration have frequently been cited as an objectively ordinary treatment which, therefore, must never be forgone. However, artificial nutrition and hydration can be very burdensome to patients. Artificial nutrition and hydration immobilize the patient to a large degree, can be extremely uncomfortable (restraints are sometimes used to prevent patients from removing nasogastric tubes), and can entail serious risks (for example, surgical risks from insertion of a gastrostomy tube and the risk of aspiration pneumonia with a nasogastric tube).

Aside from the ordinary vs extraordinary argument, the right to refuse artificial nutrition and hydration has also been contested by some because the provision of food and water has a symbolic significance as an expression of care and compassion.[19] These commentators argue that withdrawing or withholding food and water is a form of abandonment and will cause the patient to die of starvation and/or thirst. However, it is far from evident that providing nutrients through a nasogastric tube to a patient for whom it is unwanted is comparable to the typical human ways of feeding those who are hungry.[18] In addition, discomforting symptoms can be palliated so that a death that occurs after forgoing artificial nutrition and/or hydration is not marked by substantial suffering.[20,21] Such care requires constant attention to the patient's needs. Therefore, when comfort care is maintained, respecting a patient's decision to forgo artificial nutrition and hydration will not constitute an abandonment of the patient, symbolic or otherwise.

There is also no ethical distinction between withdrawing and withholding life-sustaining treatment.[4,15,17] Withdrawing life support may be emotionally more difficult than withholding life support because the physician performs an action that hastens death. When life-sustaining treatment is withheld, on the other hand, death occurs because of an omission rather than an action. However, as most bioethicists now recognize, such a distinction lacks ethical significance.[4,15,17] First, the distinction is often meaningless. For example, if a physician fails to provide a tube feeding at the scheduled time, would it be a withholding or a withdrawing of treatment? Second, ethical relevance does not lie with the distinction between acts and omissions, but with other factors such as the motivation and professional obligations of the physician. For example, refusing to initiate ventilator support despite the patient's need and request because the physician has been promised a share of the patient's inheritance is clearly ethically more objectionable than stopping a ventilator for a patient who has competently decided to forgo it. Third, prohibiting the withdrawal of life support would inappropriately affect a patient's decision to initiate such treatment. If treatment cannot be stopped once it is initiated, patients and physicians may be more reluctant to begin treatment when there is a possibility that the patient may later want the treatment withdrawn.[4]

While the principle of autonomy requires that physicians respect competent patients' requests to forgo life-sustaining treatments, there are potential negative consequences of such a policy. First, deaths may occur as a result of uninformed decisions or from pain and suffering that could be relieved with measures that will not cause the patient's death. Further, subtle or overt pressures from family, physicians, or society to forgo life-sustaining treatment may render the patient's choice less than free.

These pressures could revolve around beliefs that such patients' lives no longer possess social worth and are an unjustifiable drain of limited health resources.

The physician must ensure that the patient has the capacity to make medical decisions before carrying out the patient's decision to forgo (or receive) life-sustaining treatment. In particular, physicians must be aware that the patient's decision-making capacity can be diminished by a misunderstanding of the medical prognosis and options or by a treatable state of depression. It is also essential that all efforts be made to maximize the comfort and dignity of patients who are dependent on life-sustaining treatment and that patients be assured of these efforts. With such assurances, patients will be less likely to forgo life support because of suffering or anticipated suffering that could be palliated.

The potential pressures on patients to forgo life-sustaining treatments are an important concern. The Council believes that the medical profession must be vigilant against such tendencies, but that the greater policy risk is of undermining patient autonomy.

PROVIDING PALLIATIVE TREATMENTS THAT MAY HAVE FATAL SIDE EFFECTS

Health care professionals have an ethical duty to provide optimal palliative care to dying patients. At present, many physicians are not informed about the appropriate doses, frequency of doses, and alternate modalities of pain control for patients with severe chronic pain. In particular, inappropriate concerns about addiction too often inhibit physicians from providing adequate analgesia to dying patients. Physicians should inform the patient and the family that concentrated efforts to relieve pain will be a priority in the care of the patient, since fear

of pain is "one of the most pervasive causes of anxiety among patients, families and the public."[2]

The level of analgesia necessary to relieve the patient's pain, however, may also have the effect of shortening the patient's life. The Council stated in its 1988 report on euthanasia that "the administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life."[11] The Council maintains this position and further emphasizes that a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.

The ethical distinction between providing palliative care that may have fatal side effects and providing euthanasia is subtle because in both cases the action that causes death is performed with the purpose of relieving suffering. The intent of the former is to relieve suffering despite the fatal side effects, while the intent of the latter is to cause death as a means by which relief of suffering is achieved. Most medical treatments entail some undesirable side effects. In general, the patient has a right to decide either to risk the side effects or to forgo the treatment. It does not follow from this reasoning that a patient also has a right to choose euthanasia as a medical treatment for their suffering.

An important concern is that patients who are not fully informed about their prognosis and options may make decisions that unnecessarily shorten their lives. In addition, severe pain might diminish the patient's capacity to decide whether to choose a treatment that risks death. Caution when determining decision-making capacity in this

situation, therefore, must be exercised, and patients should be fully informed.

EUTHANASIA

Euthanasia is the medical administration of a lethal agent in order to relieve a patient's intolerable and untreatable suffering. Whether or not a physician may use the skills or knowledge of medicine to cause an "easy" death for a patient who requests such assistance has been debated as early as the time of Hippocrates. Recently, euthanasia has been gaining support from the public and some in the medical profession. In the Netherlands, while physician-performed euthanasia remains illegal, physicians have not been prosecuted since 1984 when they follow certain criteria.[23] These criteria include that (1) euthanasia is explicitly and repeatedly requested by the patient and there is no doubt that the patient wants to die; (2) the mental and physical suffering is severe with no prospect for relief; (3) the patient's decision is well-informed, free, and enduring; (4) all options for alternate care have been exhausted or refused by the patient; and (5) the physician consults another physician.[24] The frequency of euthanasia in the Netherlands has been estimated to range from 2000 to 20000 persons per year.[23] Recently, the first nationwide study of the practice of euthanasia in the Netherlands estimated the incidence of euthanasia to be 1900 persons per year.[25]

In the United States there has been growing public support for legalized euthanasia. The Hemlock Society, an organization dedicated to legalizing voluntary euthanasia and assisted suicide, has doubled its membership in the past 5 years to approximately 33000.[26] Recently, an initiative in Washington State that would have legalized euthanasia for terminally ill patients was put to a vote. Although the

initiative was unsuccessful, 44% of the voters supported the initiative.[27]

Though the principle of patient autonomy requires that competent patients be given the opportunity to choose among offered medical treatments and to forgo any treatment, it does not give patients the right to have a physician perform a treatment to which the physician has objections. Though patients have a right to refuse life-sustaining treatment, they do not have a right to receive euthanasia. There is an autonomy interest in directing one's death, but this interest is more limited in the case of euthanasia than in the case of refusing life support.

The question remains whether it is ethical for a physician to agree to perform euthanasia. To approach this question one must look to the principles of beneficence and nonmaleficence and to the larger policy implications of condoning physician-performed euthanasia.

Can euthanasia ever constitute sound medical treatment? Any treatment designed to cause death is generally considered detrimental to the patient's well-being, and therefore unsound. However, proponents of euthanasia argue that euthanasia is a sound treatment of last resort for the relief of intolerable pain and suffering. From the perspective of competent patients who request euthanasia in the face of such suffering, death may be preferable, on balance, to continued life.

On the other hand, most pain and suffering can be alleviated. The technology of pain management has advanced to the point where most pain is now controllable. The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.[22]

There may be cases, however, where a patient's pain and suffering is not reduced to a tolerable level and the patient requests a physician to help him or her die.[2,22] If a patient's pain and suffering are unrelievable and intolerable, using medical expertise to aid an easy death on the request of the patient might seem to be the humane and beneficent treatment for the patient.

However, there are serious risks associated with a policy allowing physician-performed euthanasia. There is a long-standing prohibition against physicians killing their patients, based on a commitment that medicine is a profession dedicated to healing, and that its tools should not be used to cause patients' deaths. Weakening this prohibition against euthanasia, even in the most compelling situations, has troubling implications.[28,29] Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly. Two noted ethicists have expressed the role of this prohibition:

> The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumentally and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.[17]

If euthanasia by physicians were to be condoned, the fact that physicians could offer death as a medical treatment might undermine public trust in medicine's dedication to preserving the life and health of patients.[26] Some patients may fear the prospect of involuntary or nonvoluntary euthanasia if their lives are no longer deemed valuable as judged by physicians, their family, or society.[30] Other patients who trust their physicians' judgments may not feel

free to resist the suggestion that euthanasia may be appropriate for them.[30-32]

Another risk is that physicians and other health care providers may be more reluctant to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death. Caring for dying patients is taxing on physicians who must face issues of their own mortality in the process, and who often perceive such care as a reminder of their failure to cure these patients.[4,15] In addition, the increasing pressure to reduce health care costs may serve as another motivation to favor euthanasia over longer-term comfort care.

Allowing physicians to perform euthanasia for a limited group of patients who may truly benefit from it will present difficult line-drawing problems for medicine and society. In specific cases it may be hard to distinguish which cases fit the criteria established for euthanasia. For example, if the existence of unbearable pain and suffering was a criterion for euthanasia, the definition of unbearable pain and suffering could be subject to different interpretations.

Furthermore, determining whether a patient will benefit from euthanasia requires an intimate understanding of the patient's concerns, values, and pressures that may be prompting the euthanasia request. In the Netherlands, physicians who provide euthanasia generally have a lifelong relationship with the patient and the patient's family, which enables the physician to have access to this vital information.[33] In the United States, however, physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's request for euthanasia.

More broadly, the line-drawing necessary for the establishment of criteria for euthanasia is also problematic.

If competent patients can receive euthanasia, can family members request euthanasia for an incompetent patient? Would it be acceptable for physicians to perform euthanasia on any competent individuals who request it? Furthermore, since it will be physicians and the state who ultimately answer these questions, value judgments about patients' lives will be made by a person or entity other than the patients.

Since it is unclear at this time where these lines should be drawn, the proposition of allowing euthanasia is particularly troublesome. A potential exists for a gradual distortion of the role of medicine into something that starkly contrasts with the current vision of a profession dedicated to healing and comforting.

Furthermore, in the United States there is currently little data regarding the number of euthanasia requests, the concerns behind the requests, the types and degree of intolerable and unrelievable suffering, or the number of requests that have been granted by health care providers. Before euthanasia can ever be considered a legitimate medical treatment in this country, the needs behind the demand for physician-provided euthanasia must be examined more thoroughly and addressed more effectively. A thorough examination would require a more open discussion of euthanasia and the needs of patients who are making requests. The existence of patients who find their situations so unbearable that they request help from their physicians to die must be acknowledged, and the concerns of these patients must be a primary focus of medicine. Rather than condoning physician-provided euthanasia, medicine must first respond by striving to identify and address the concerns and needs of dying patients.

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide has only recently become the focus of public attention. In June 1990, Dr Jack Kevorkian assisted the death of a person with the use of a "suicide machine," which he invented. This case has been criticized by many for the irresponsible way in which it was carried out by the physician.[26] Kevorkian has since used his suicide machine to assist the suicides of two more persons. Last March, an article was published in the *New England Journal of Medicine* by a physician who described his role in assisting his patient's suicide.[34] The care and compassion evidenced by the physician and the reasoned decision-making process of the patient marked this account as truly compelling. Besides these very public cases of physician-assisted suicide, there is reason to believe that it has been occurring for some time.[2]

There is an ethically relevant distinction between euthanasia and assisted suicide that makes assisted suicide an ethically more attractive option. Physician-assisted suicide affords a patient a more autonomous way of ending his or her life than does euthanasia. Since patients must perform the life-ending act themselves, they would have the added protection of being able to change their minds and stop their suicides up until the last moment.

However, the ethical objections to physician-assisted suicide are similar to those of euthanasia since both are essentially interventions intended to cause death. Physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also has many of the same societal risks as euthanasia, including the potential for coercive financial and societal pressures on patients to choose suicide. Further, determining the criteria for assisting a patient's suicide and determining

whether a particular patient meets the criteria are as problematic as deciding who may receive euthanasia.

While in highly sympathetic cases physician-assisted suicide may seem to constitute beneficent care, due to the potential for grave harm the medical profession cannot condone physician-assisted suicide at this time. The medical profession instead must strive to identify the concerns behind patients' requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care.

CONCLUSIONS

* The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

* There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

* Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

* Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control

may decrease dramatically the demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great in this culture to condone euthanasia or physician-assisted suicide at this time.

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MODEL PENAL CODE

§ 210.5 Causing or Aiding Suicide

. . .

(2) **Aiding or Soliciting Suicide as an Independent Offense.** A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor.

STATE STATUTES

ALASKA

Sec. 1141.120. Manslaughter. (a) A person commits the crime of manslaughter if the person

. . .

(2) intentionally aids another person to commit suicide.

ARIZONA

§ 13-1103. Manslaughter; classification

A. A person commits manslaughter by:

. . .

3. Intentionally aiding another to commit suicide; or

ARKANSAS

5-10-104. Manslaughter.

. . .

(2) He purposely causes or aids another person to commit suicide;

CALIFORNIA

§ 401. Suicide; aiding, advising, or encouraging

Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.

COLORADO

18-3-104. Manslaughter. (1) A person commits the crime of manslaughter if:

. . .

(b) Such person intentionally causes or aids another person to commit suicide; or

CONNECTICUT

§ 53A-56. Manslaughter in the second degree: Class C felony

(a) A person is guilty of manslaughter in the second degree when: . . . (2) he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide.

Commission Comment--1971

Manslaughter in the second degree. This section covers two types of homicide: recklessly causing the death of another; and intentionally causing or aiding another person to commit suicide.

. . .

The second part, causing or aiding a suicide, is aimed at such situations as aiding, out of the feelings of sympathy, the suicide of one inflicted with a painful and incurable disease. While such conduct is blameworthy, the possible mitigating circumstances justify its treatment as manslaughter, rather than murder.

DELAWARE

§ 645. Promoting suicide; class F felony [Amendment effective with respect to crimes committed June 30, 1990, or thereafter].

A person is guilty of promoting suicide when he intentionally causes or aids another person to attempt suicide, or when he intentionally aids another person to commit suicide.

FLORIDA

782.08. Assisting self-murder

Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

ILLINOIS

12-31. Inducement to commit suicide

§ 12-31. Inducement to Commit Suicide. (a) A person commits the offense of inducement to commit suicide when he coerces another to commit suicide and the other person commits suicide as a direct result of the coercion, and he exercises substantial control over the other person through (1) control of the other person's physical location or circumstances; (2) use of psychological pressure; or (3) use of actual or ostensible religious, political, social, philosophical or other principles.

INDIANA

35-42-1-2.5 Assisting suicide.--(a) This section does not apply to the following:

(1) A licensed health care provider who administers, prescribes, or dispenses medications or procedures to

relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death.

(2) The withholding or withdrawing of medical treatment or life-prolonging procedures by a licensed health care provider, including pursuant to IC 16-8-11 (living wills and life-prolonging procedures), IC 16-8-12 (health care consent), or IC 30-5 (power of attorney).

(b) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following commits assisting suicide, a Class C felony:

(1) Provides the physical means by which the other person attempts or commits suicide.

(2) Participates in a physical act by which the other person attempts or commits suicide.

KANSAS

21-3406. Assisting suicide. Assisting suicide is intentionally advising, encouraging or assisting another in the taking of the other's life which results in a suicide or attempted suicide.

Assisting suicide is a severity level 9, person felony.

MAINE

§ 204. Aiding or soliciting suicide

1. A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide.

2. Aiding or soliciting suicide is a Class D crime.

Comment to former section 206--1975

There is no counterpart to this section in the present law. It is included in the code in order to deter conduct aimed at causing another to take his life. The participation of the victim in bringing about his own death does not make the forbidden conduct free from fault. The requirement that there be a successful or unsuccessful suicide attempt adds a safeguard designed to corroborate the defendant's intention. [Footnote omitted.]

MICHIGAN

AN ACT to ◆ [prohibit certain acts pertaining to the assistance of suicide]; to provide for the development of legislative recommendations concerning certain issues related to death and dying [, including assistance of suicide]; ◆ [to create the Michigan commission on death and dying]; [to prescribe its membership, powers, and duties;] to prescribe penalties; and to repeal certain parts of this act on a specific date.

§28.547(121) Commission on death and dying; creation.] Sec. 1. (1) The legislature finds that the voluntary self-termination of human life, with or without assistance, raises serious ethical and public health questions in the state. To study this problem and to develop recommendations for legislation, the Michigan commission on death and dying is created.

Effective date.] [(2) This section shall take effect February 25, 1993.] (MCL §752.1021.)

§28.547(122) Definitions.] Sec. 2. (1) As used in this act:

(a) "Commission" means the Michigan commission on death and dying created in section 3.

(b) "Legislative council" means the legislative council established under section 15 of article IV of the state constitution of 1963.

(c) "Licensed health care professional" means any of the following:

(i) A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code [, being sections 333.17001 to 333.17088 and 333.17501 to 333.17556 of the Michigan Compiled Laws].

(ii) A registered nurse or licensed practical nurse licensed or authorized to practice under part 172 of the public health code [, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws].

(iii) A pharmacist licensed under part 177 of the public health code[, being sections 333.17701 to 333.17770 of the Michigan Compiled Laws].

(d) "Patient" means a person who engages in an act of voluntary self-termination.

(e) "Public health code" means Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(f) "The voluntary self-termination of life", "voluntary self-termination", and "self-termination" mean conduct by which a person expresses the specific intent to end, and attempts to cause the end of, his or her life, but do not include the administration of medication or medical treatment intended by a person to relieve his or her pain or discomfort, unless that administration is also independently and specifically intended by the person to cause the end of his or her life.

Effective date.] [(2) This section shall take effect February 25, 1993.] (MCL §752.1022.)

§28.547(123) Nomination and appointment of members.] Sec. 3.(1) The Michigan commission on death and dying is created within the 'egislative council. In

accordance with its own rules and procedures, each of the following may nominate 2 persons for appointment to the commission:

(a) American association of retired persons.
(b) American civil liberties union of Michigan.
(c) Citizens for better care.
(d) Health care association of Michigan.
(e) Hemlock of Michigan.
(f) Michigan association for retarded citizens.
(g) Michigan association of osteopathic physicians and surgeons.
(h) Michigan association of suicidology.
(i) Michigan council on independent living.
(j) Michigan head injury survivor's council.
(k) Michigan hospice organization.
(l) Michigan hospital association.
(m) Michigan nonprofit homes association.
(n) Michigan nurses association.
(o) Michigan psychiatric society.
(p) Michigan psychological association.
(q) Michigan senior advocates council.
(r) Michigan state medical society.
(s) National association of social workers, Michigan division.
(t) Right to life of Michigan, inc.
(u) State bar of Michigan.
(v) Prosecuting attorneys association of Michigan.

Legislative council; selection of commission member and alternate.] (2) Within 30 days after receiving notice of the nominations of an organization listed in subsection (1), the chairperson and alternate chairperson of the legislative council shall select from the nominees of that organization a member and a person to serve as that member's alternate on the commission.

Majority of members to constitute quorum.] (3) A majority of commission members appointed constitute a quorum.

Initial meeting; election of officers; establishment of rules of proceeding; rights of alternate members.] (4) The commission shall convene its first meeting within 90 days after the effective date of this act, at which the members shall elect from members of the commission a chairperson, vice-chairperson, and secretary. The commission shall establish rules governing commission proceedings. These rules shall provide alternate members with full rights of participation, other than voting, in all commission proceedings.

Subsequent meetings; calling of meetings by chairperson or commission majority; notice.] (5) Following its first meeting, the commission shall meet as often as necessary to fulfill its duties under this act. Either the chairperson or a majority of the appointed members may call a meeting upon 7 days' written notice to the commission members.

Deliberations; involvement of members of the public and certain groups.] (6) In its deliberations, the commission shall provide for substantial involvement from the academic, health care, legal, and religious communities, as well as from members of the general public.

Death or absence of member; duties of alternate.] (7) Upon the death or resignation of a commission member, the person serving as his or her alternate shall succeed that member. If a member of the commission is absent from a commission meeting, the person serving as his or her alternate shall act as a member of the commission at that meeting.

Effective date.] [(8) This section shall take effect February 25, 1993.] (MCL §752.1023.)

§28.547(124) Recommendations to legislature; factors to consider.] Sec. 4. [(1)] Within 15 months after the effective date of this act, the commission shall develop and submit to the legislature recommendations as to legislation concerning the voluntary self-termination of life. In developing these recommendations, the commission shall consider each of the following:

(a) Current data concerning voluntary self-termination, including each of the following:

(i) The current self-termination rate in the state, compared with historical levels.

(ii) The causes of voluntary self-termination, and in particular each of the following:

(A) The role of alcohol and other drugs.

(B) The role of age, disease, and disability.

(iii) Past and current Michigan law concerning voluntary self-termination, including the status of persons who assist a patient's self-termination, and in particular the effect of any relevant law enacted during the 86th Legislature.

(iv) The laws of other states concerning voluntary self-termination, and in particular the effect of those laws on the rate of self-termination.

(b) The proper aims of legislation affecting voluntary self-termination, including each of the following:

(i) The existence of a societal consensus in the state on the morality of the voluntary self-termination of life, including the morality of other persons assisting a patient's self-termination.

(ii) The significance of each of the following:

(A) The attitudes of a patient's family regarding his or her voluntary self-termination.

(B) The cause of a patient's act of self-termination, including apprehension or existence of physical pain, disease, or disability.

(iii) Whether to differentiate among the following causes of voluntary self-termination:

(A) Physical conditions, as distinguished from psychological conditions.

(B) Physical conditions that will inevitably cause death, as distinguished from physical conditions with which a patient may survive indefinitely.

(C) Withdrawing or withholding medical treatment, as distinguished from administering medication, if both are in furtherance of a process of voluntary self-termination.

(iv) With respect to how the law should treat a person who assists a patient's voluntary self-termination, whether to differentiate based on the following:

(A) The nature of the assistance, including inaction; noncausal facilitation; information transmission; encouragement; providing the physical means of self-termination; active participation without immediate risk to the person assisting; and active participation that incurs immediate risk to the person assisting, such a suicide pacts.

(B) The motive of the person assisting, including compassion, fear for his or her own safety, and fear for the safety of the patient.

(C) The patient's awareness of his or her true condition, including the possibility of mistake or deception.

(v) The relevance of each of the following:

(A) The legal status of suicide.

(B) The legal status of living wills.

(C) The right to execute a durable power of attorney for health care, as provided in section 496 of the revised probate code, Act No. 642 of the Public Acts of 1978, being section 700.496 of the Michigan Compiled Laws.

(D) The common-law right of a competent adult to refuse medical care or treatment.

(E) Constitutional rights of free speech, free exercise of religion, and privacy, and constitutional prohibitions on the establishment of religion.

(c) The most efficient method of preventing voluntary self-terminations, to the extent prevention is a proper aim of legislation. In particular, the commission shall consider each of the following:

(i) The costs of various methods of preventing voluntary self-terminations, including the use of any of the following:

(A) Public health measures, such as crisis therapy and suicide counseling services.

(B) Tort law.

(C) Criminal law, including the desirability of criminalizing suicide or attempted suicide.

(D) Civil sanctions, including the denial of inheritance and requirements of community service and mandatory counseling.

(ii) The likely effect of any of the methods listed in subparagraph (i) on the self-termination rate, and in particular the probability that a particular method might cause the self-termination rate to increase.

(iii) The impact of any of the methods listed in subparagraph (i) on the practice of medicine and the availability of health care in the state.

(iv) Whether current state law is adequate to address the question of voluntary self-termination in the state.

(d) Appropriate guidelines and safeguards regarding voluntary self-terminations the law should allow, including the advisability of allowing, in limited cases, the administering of medication in furtherance of a process of voluntary self-termination.

(e) Any other factors the commission considers necessary in developing recommendations for legislation concerning the voluntary self-termination of life.

Effective date.] [(2) This section shall take effect February 25, 1993.] (MCL §752.1024.)

§28.547(125) Open meetings act; applicability.] Sec. 5. [(1)] The business of the commission shall be conducted in compliance with the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

§28.547(126) Freedom of information act; applicability; writings prepared or possessed by commission.] Sec. 6. [(1)] A writing prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function shall be made available to the public in compliance with the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

§28.547(127) Assistance to suicide; felony; penalty.] Sec. 7. (1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both:

(a) Provides the physical means by which the other person attempts or commits suicide.

(b) Participates in a physical act by which the other person attempts or commits suicide.

Exception; withholding or withdrawing medical treatment.] (2) Subsection (1) shall ◆ [not apply to withholding or withdrawing medical treatment].

Exception; medications and procedures not intended to cause death.] (3) ◆ [Subsection (1) does not apply to prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort and

not to cause death, even if the medication or procedure may hasten or increase the risk of death.]

Effective date.] [(4) This section shall take effect February 25, 1993.]

Prospective repeal.] [(5)] ◆ This section is repealed effective 6 months after the date the commission makes its recommendations to the legislature pursuant to section 4. (MCL §752.1027.)

MINNESOTA

609.215. Suicide

Subdivision 1. Aiding suicide. Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than $30,000, or both.

Subd. 2. Aiding attempted suicide. Whoever intentionally advises, encourages, or assists another who attempts but fails to take the other's own life may be sentenced to imprisonment for not more than seven years or to payment of a fine of not more than $14,000, or both.

Subd. 3. Acts or omissions not considered aiding suicide or aiding attempted suicide. (a) A health care provider, as defined in section 145B.02, subdivision 6, who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.

(b) A health care provider, as defined in section 145B.02, subdivision 6, who withholds or withdraws a life-sustaining procedure in compliance with chapter 145B or in

accordance with reasonable medical practice does not violate this section.

Subd. 4. Injunctive relief. A cause of action for injunctive relief may be maintained against any person who is reasonably believed to be about to violate or who is in the course of violating this section by any person who is:

(1) the spouse, parent, child, or sibling of the person who would commit suicide;

(2) an heir or a beneficiary under a life insurance policy of the person who would commit suicide;

(3) a health care provider of the person who would commit suicide;

(4) a person authorized to prosecute or enforce the laws of this state; or

(5) a legally appointed guardian or conservator of the person who would have committed suicide.

Subd. 5. Civil damages. A person given standing by subdivision 4, clause (1), (2), or (5), or the person would have committed suicide, in the case of an attempt, may maintain a cause of action against any person who violates or who attempts to violate subdivision 1 or 2 for compensatory damages and punitive damages as provided in section 549.20. A person described in subdivision 4, clause (4), may maintain a cause of action against a person who violates or attempts to violate subdivision 1 or 2 for a civil penalty of up to $50,000 on behalf of the state. An action under this subdivision may be brought whether or not the plaintiff had prior knowledge of the violation or attempt.

Subd. 6. Attorney fees. Reasonable attorney fees shall be awarded to the prevailing plaintiff in a civil action brought under subdivision 4 or 5.

MISSISSIPPI

§ 97-3-49. Suicide--aiding.

A person who wilfully, or in any manner, advises, encourages, abets, or assists another person to take, or in taking, the latter's life, or in attempting to take the latter's life, is guilty of felony and, on conviction, shall be punished by imprisonment in the penitentiary not exceeding ten years, or by fine not exceeding one thousand dollars, and imprisonment in the county jail not exceeding one year.

MONTANA

45-5-105. Aiding or soliciting suicide. (1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide.

(2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

NEBRASKA

28-307. Assisting suicide, defined; penalty. (1) A person commits assisting suicide when, with intent to assist another person in committing suicide, he aids and abets him in committing or attempting to commit suicide.

(2) Assisting suicide is a Class IV felony.

NEW HAMPSHIRE

630:4 Causing or Aiding Suicide.

I. A person is guilty of causing or aiding suicide if he purposely aids or solicits another to commit suicide.

II. Causing or aiding suicide is a class B felony if the actor's conduct causes such suicide or an attempted suicide. Otherwise it is a misdemeanor.

NEW JERSEY

2C:11-6. Aiding suicide

A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.

NEW MEXICO

30-2-4. Assisting suicide.

Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth degree felony.

NEW YORK

§ 120.30 Promoting a suicide attempt

A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide.

Promoting a suicide attempt is a class E felony.

§ 120.35 Promoting a suicide attempt; when punishable as attempt to commit murder

A person who engages in conduct constituting both the offense of promoting a suicide attempt and the offense of attempt to commit murder may not be convicted of attempt to commit murder unless he causes or aids the suicide attempt by the use of duress or deception.

OKLAHOMA

§ 813. Aiding suicide

Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide.

§ 814. Furnishing weapon or drug

Every person who willfully furnishes another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life, is guilty of aiding suicide, if such person thereafter employs such instrument or drug in taking his own life.

§ 815. Aid in attempt to commit suicide

Every person who willfully aids another in attempting to take his own life, in any manner which by the preceding sections [footnote omitted] would have amounted to aiding suicide if the person assisted had actually taken his own life, is guilty of aiding an attempt at suicide.

§ 816. Incapacity of person committing or attempting suicide no defense

It is no defense to a prosecution for aiding suicide or aiding an attempt at suicide, that the person who committed or attempted to commit the suicide was not a person deemed capable of committing crime.

§ 817. Punishment for aiding suicide

Every person guilty of aiding suicide is punishable by imprisonment in the penitentiary for not less than seven (7) years.

§ 818. Punishment for aiding an attempt at suicide

Every person guilty of aiding an attempt at suicide is punishable by imprisonment in the penitentiary not exceeding two (2) years, or by a fine not exceeding One Thousand Dollars ($1,000.00), or both.

OREGON

163.125 Manslaughter in the second degree

(1) Criminal homicide constitutes manslaughter in the second degree when:

. . .

(b) A person intentionally causes or aids another person to commit suicide.

PENNSYLVANIA

§ 2505. Causing or aiding suicide

. . .

(b) Aiding or soliciting suicide as an independent offense.--A person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor of the second degree.

SOUTH DAKOTA

22-16-37. Aiding and abetting suicide as felony. Any person who intentionally in any manner advises, encourages, abets or assists another in taking his own life is guilty of a Class 6 felony.

TEXAS

§ 22.08. Aiding Suicide

(a) A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide.

(b) An offense under this section is a Class C misdemeanor unless the actor's conduct causes suicide or

attempted suicide that results in serious bodily injury, in which event the offense is a felony of the third degree.

WISCONSIN

940.12 Assisting suicide

Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D felony.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	DECLARATION OF JOHN P. GEYMAN, M.D.
Defendants.	)	

JOHN P. GEYMAN, M.D. declares:

1. I am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of California in 1960.

3. From 1976 through 1990 I served as Professor and Chairman of the Department of Family Medicine at the School of Medicine at the University of Washington. Since stepping down as Chairman of the Department, I have continued to serve as Professor of Family Medicine in the Department of Family Medicine at the School of Medicine at the University of Washington. I held privileges at the University of Washington Medical Center from 1976 to 1993. Since 1993 I have continued as Professor Emeritus of Family Medicine at the University of Washington and have returned to rural practice at the Inter-Island Medical Center, Friday Harbor, Washington.

4. I am a charter fellow of the American Academy of Family Physicians and am certified by the American Board of Family Practice.

5. In addition to my academic appointments, I have practiced family medicine in a number of different practices and places over the course of my career.

6. I am a member of the American Medical Association, the American Academy of Family Physicians, the Society of Teachers of Family Medicine, the Washington State Medical Association, the King County Medical Society, the American Association for Advancement in Science, and the Institute of Medicine.

7. I am recognized in Who's Who in Health Care, Who's Who in America, and the International Who's Who in Medicine.

8. I have published over 70 articles related to the practice of family medicine in medical journals. I have

also authored numerous books, book chapters, and monographs in the field. I am the founding editor of the Journal of Family Practice (1974-1990) and, since 1990, have served as editor of the Journal of the American Board of Family Practice.

9. My complete curriculum vitae is attached hereto.

10. In my 35 years experience as a practicing family physician and medical educator I have had many occasions to witness mentally competent, terminally ill adult patients confront issues relating to their dying process, including the issue of hastening the dying process. Over this period, I have also seen many patients endure unnecessarily prolonged pain and suffering in the dying process under circumstances where patients, for one reason or another, had insufficient participation in deciding upon their terminal care.

11. Physicians caring for patients with terminal illnesses necessarily become directly involved in assisting such patients and their families to understand the prognosis, expected course and options for either therapeutic or palliative care. In the presence of terminal illness, the shared goal of medical care at some point becomes comfort care rather than cure. The physician's task becomes one of alleviating pain and suffering as much as possible.

12. With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt. As a result, many experience prolonged deaths often involving pain, suffering and loss of dignity. In reaction to this problem, an increasing number of patients want more direct control over the type of care they receive in the last stage of their lives. A subset of dying patients desire to shorten their dying process and thereby

avoid a lingering death and associated pain, suffering and loss of dignity.

13. Terminally ill persons who seek to hasten death by consuming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. Many terminally ill persons will be taking a variety of medications for their condition; for example, patients suffering chronic pain may be taking high doses of morphine or other narcotics and may have developed a high tolerance to narcotics. Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task.

14. It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try do so without medical advice. These efforts are often unsuccessful and can cause the patient and family increased anxiety, pain and suffering. Very often, patients who survive a failed suicide attempt find themselves in worse shape than before the attempt.

15. There is often a severe adverse emotional and psychological effect on terminally ill patients who either are unable to broach the subject of their desire to hasten their death with their physician because of the current prohibition or broach the subject but are rebuffed. These patients feel abandoned by their physician when most in need of help.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Washington, this 10th day of March, 1994.

/s/
JOHN P. GEYMAN, M.D.

CURRICULUM VITAE

John P. Geyman, M.D.

Birthdate:	February 9, 1931
Address:	4909 C Hannah Road Friday Harbor, Washington 98250
	Married 36 years 3 sons (ages 31, 32, and 33)
SSN:	562-50-0853

PRESENT POSITION:

10/01/90-Present	Professor of Family Medicine, Department of Family Medicine, School of Medicine, University of Washington, Seattle, Washington

PREVIOUS POSITIONS:

12/1/76-9/30/90	Professor and Chairman, Department of Family Medicine, School of Medicine, University of Washington, Seattle, Washington
9/1/72-11/76	Professor and Vice Chairman, Department of Family Practice, School of Medicine, University of California - Davis
9/1/72-11/76	Director, University of California - Davis, Family Practice Residency Network Program
1971-72	Chairman, Division of Family Practice, University of Utah College of Medicine, Salt Lake City, Utah

1971-72	Director, University of Utah Family Practice Residency Program, University of Utah Affiliated Hospitals for Family Practice
1969-71	Director, University of California - San Francisco, Community Hospital of Sonoma County Family Practice Program
1969-71	Project Coordinator, University of California - San Francisco, Sonoma County Demonstration Project, Regional Medical Programs (Area I)

EDUCATION:

Undergraduate:

1948-52	Princeton University, A.B. (Geology), Princeton, New Jersey
1955-56	University of California, Premedical, Berkeley, California

Medical School:

1956-60	University of California School of Medicine, M.D., San Francisco, California

Postdoctoral:

1960-61	Los Angeles County General Hospital, Rotating Internship, Los Angeles, California
1961-63	Sonoma County Hospital, General Practice Residency, Santa Rosa, California

CERTIFICATION:

1973	Charter Fellow, American Academy of Family Physicians
Since 1971	Charter Member of American Board of Family Practice (certified in February 1971, recertified in December 1977, September 1983, and October 1990)

LICENSURE:

1977-Present	(Medical)	State of Washington	No. 15618
1977-Present	(Narcotics)	State of Washington	No. AG-5331703
1961-85	(Medical)	State of California	No. A-19658
1961-85	(Narcotics)	State of California	No. 18098

PRACTICE EXPERIENCE:

1963-69	Private Practice, Solo General Practice, Mount Shasta, California
1967-69	Director, Coronary Care Unit, Mount Shasta Community Hospital
1990-Present	Part-Time Group Practice, Inter-Island Medical Center, Friday Harbor, Washington.

HOSPITAL STAFF MEMBERSHIPS:

Present:

1/1/77-Present	University of Washington Medical Center, Seattle, Washington
9/1/72-1976	Sacramento Medical Center, Sacramento, California
1963-69	Mount Shasta Community Hospital, Mount Shasta, California
1969-71	Community Hospital of Sonoma County, Santa Rosa, California

1971-72	University Hospital, University of Utah Medical Center, Salt Lake City, Utah

PROFESSIONAL ASSOCIATIONS:

1960-Present	Gold Headed Cane Society (University of California, School of Medicine, San Francisco)
1963-Present	American Medical Association
1964-Present	American Academy of Family Physicians
1969-Present	Society of Teachers of Family Medicine
1978-Present	Washington State Medical Association
1978-Present	King County Medical Society
1978-1990	Association of Departments of Family Medicine
1983-Present	American Association for Advancement of Science

OFFICES HELD:

1959-60	President, Senior Class, University of California School of Medicine
1967	President, Siskiyou County Medical Society
1968	Chief of Staff, Mount Shasta Community Hospital
1968-69	President, Siskiyou County Comprehensive Health planning Council
1969	Board of Trustees, College of Siskiyou, Weed, California

HONORS:

1960	Gold Headed Cane Award, University of California School of Medicine (San Francisco)
1974	American Men and Women of Science

1977	Who's Who in Health Care
1979	Who's Who in America
1980	Certificate of Excellence, Society of Teachers of Family Medicine
1980	Thomas W. Johnson Award for contributions in family practice education, American Academy of Family Physicians
1985	Member, Institute of Medicine, National Academy of Sciences
1986	International Who's Who in Medicine
1988	Alumnus of the Year, 1988, Community Hospital Alumni Association, Santa Rosa, California
1990	Curtis B. Hames Research Award, North America Primary Care Research Group and Society of Teachers in Family Medicine
1992	Fellow, Royal Society of Medicine, New York and London.

ACADEMIC APPOINTMENTS:

12/1/76-Present	Professor of Family Medicine, University of Washington School of Medicine
9/1/72-11/76	Professor of Family Practice, University of California Davis, School of Medicine
1971-72	Associate Professor of Community and Family Medicine, University of Utah College of Medicine
1969-71	Assistant Clinical Professor of Ambulatory and Community Medicine, University of California, San Francisco

SELECTED COMMITTEES:

University of California - Davis School of Medicine:

1972-76	Admissions Committee
1973-75	Task Force on Planning for Medical School Facilities: Subgroup on Patient Care Needs, Inland Northern California, 1980-85

California Medical Association:

1973-76	Advisory Panel on General and Family Practice

Society of Teachers of Family Medicine:

1971-75	Program Committee
1971-75	Graduate Objectives Committee
1973-78	Education Committee
1975-80	Audio-Visual Review Committee (Chairman)
1979-81	Faculty Development Task Force

University of Washington School of Medicine:

1977-1990	Medical School Executive Committee
1978-1979	Steering Committee of Executive Committee
1978-1984	Appointments and Promotions Committee
1981-1984 and	Academic Affairs Committee
1987-1990	Academic Affairs Committee
1985-1990	Ad Hoc Committee on International Educational Activities of the School of Medicine
1985-1989	Joint Conference Committee
1986-1990	Regional Affairs Committee
1986-Present	Medex Advisory Committee
1987	Chairman, Ad Hoc Committee to Consider Clinical Track

1987-1990	Finance Committee, Associated University Physicians
1987-1988	Awards and Prizes Committee
1988-1992	Admissions Committee
1989-1990	Admissions Review Task Force Committee, Dean's Office

RELATED ACTIVITIES:

1972-78	Consultant for Survey Team for Review of Physician Assistant Programs, American Medical Association
1973-79	Member of Examination Panel - Pictorial Subcommittee, American Board of Family Practice (Chairman, 1975-79)
1973-Present	Regional Consultant for Family Practice Residencies, American Academy of Family Practice
1974-76	Consultant for Family Practice Medical Education, California Health Manpower Policy Commission
1974-Present	Consultant for Family Practice Grant Program, Bureau of Health Resources Development, Department of Health, Education, and Welfare
1975-80	Consultant for Residency Assistance Program, Sponsored by American Academy of Family Physicians, American Board of Family Practice, and the Society of Teachers of Family Medicine
1981-83	Technical Advisory Committee, Financing of Graduate Medical Education Study, Department of Health and Human Services

1981-83	Member, Family Practice Board of Advisors, MULTICARE (National Group Practice Project)
1981-83	Member, Working Group on Fundamental Skills of General Physicians, Education of the Physician Project (AAMC)
1982	Member, Evaluation Committee for Stanford Medical School's Affiliated Family Practice Residency Program at San Jose Hospital
1983	Technical Advisory Committee for the National Study on Medical Care Outcomes, Robert Wood Johnson Foundation
1984	Advisory Panel for Study of Impact of Federal Support of Family Practice Residency Training, Policy Analysis, Inc., and Department of Health and Human Services
1984	Delegation Leader, Family Medicine Delegation to China, Taiwan, and South Korea, People-to-People Citizen Ambassador Program
11/15/85-12/15/85	Visiting Professor, Beer Sheva Medical School, Israel
1986	Delegation Leader, Family Medicine Delegation to Sweden, Soviet Union, and Norway, People-to-People Citizen Ambassador Program
1985-Present	Member, Evaluation Steering Committee for Physician Data Query (PDQ) Projects, National Cancer Institute

1986	Dean's Advisory Committee for Review of Department of Family Medicine, University of California, Irvine
1986-88	Membership Committee, Institute of Medicine
1987-Present	Ad Hoc Committee on Funding for Family Practice, Society of Teachers of Family Medicine
1988	Dean's Advisory Committee for Review of Department of Family Practice and Community Health, University of Minnesota
1988-1989	Study Group for Strategies for Supporting Graduate Medical Education in Primary Care, Institute of Medicine
1988-Present	Chairman, Ad Hoc Committee to Consider Organizational Options for Academic Family Medicine, Society of Teachers of Family Medicine and Association of Departments of Family Medicine.
1989	Invited Participant at Conference on the Future of the Generalist Physician in America, Boston, Massachusetts. Josiah Macy, Jr. Foundation.
1989-1990	Member, Board of Inter-Island Medical Center, Friday Harbor, Washington
1990	External reviewer for Department of Family and Preventive Medicine, University of Utah

1990-Present	Member, Clinical Science Committee of Association of American Medical Colleges for Selection of Distinguished Teacher Awards
1990	Invited as Panel Participant, International Family Practice Panel to select candidates for international academic positions, Faculty of Medicine, United Arab Emirates University, United Arab Emirates
1990-Present	Member, Departments of Family Medicine Review Committee, Division of Medicine, Health Resources & Services Administration, to review grant applications. Rockville, Maryland.
1991	Member, Editorial Advisory Board for Family Physicians Anxiety Education, Program, Science and Medicine, New York
1991	Invited Participant, AAMC Focus Group on Graduate Medical Education for Primary Care, Washington, D.C.
1991	Visiting Professor, University of Oregon Health Sciences Center, Portland, Oregon
1991	Invited Participant, AAMC Focus Group on Graduate Medical Education for Primary Care, Washington, D.C.
1991-1992	Member, Rural Health System Development Project Review Committee, State of Washington, Department of Health.

1992 Member, Education Committee for Statewide Health Personnel Resource Plan, State of Washington Higher Education Coordinating Board.

1992 Visiting Professor, National Taiwan University, Taipei, Taiwan, Republic of China.

1992 Visiting Professor, University of Nevada, Reno, Nevada.

EXTRA-MURAL GRANTS:

Principal Investigator, University of California Davis Family Practice Residency Program in Affiliated Hospitals for Family Practice, funded by W. K. Kellogg Foundation
(7/1/73-6/30/77: $417,164)

Project Investigator, Health Professions Special Project Grant for Preceptorship Training, funded by Department of Health, Education and Welfare, Public Health Service, National Institute of Health
(3/1/74-6/30/76: $543,306)

Principal Investigator, Family Practice Residency Training Program, University of California Davis, Sacramento Medical Center, and Affiliated Hospitals for Family Practice, funded by Department of Health, Education and Welfare, Public Health Service, National Institute of Health
(4/1/74-6/30/76: $302,653)
Supplemental Grants(4/1/74-6/30/75: $55,437) and
(7/1/75-6/30/76: $114,785)

Principal investigator, University of California Davis Family Practice Residency Program Expansion of University-Based Program involving Davis Family Practice Center, Merced Community Medical Center, and Shasta Cascade Family Practice Residency, funded by Health

Manpower Policy Commission, State of California
(7/1/75-6/30/79: $813,261)

Principal Investigator, Family Practice Residency Network Grant involving University of Washington Hospital and six affiliated hospitals with Family Medicine training programs; funded by the W. K. Kellogg Foundation
(12/1/76-8/30/82: $929,821)

Principal Investigator, Family Medicine Residency Network Training Grant involving University of Washington Hospital and six affiliated hospitals for Family Medicine, funded by Department of Health, Education and Welfare, Public Health Service
(7/1/77-6/30/80: $740,000)

Co-Investigator, Faculty Fellowship in Family Medicine, funded by the Robert Wood Johnson Foundation
(1/1/78-6/30/81: $623,832)
Renewal Grant: (7/1/81-6/30/84: $737,498)

Principal Investigator, Family Medicine Residency Training involving University of Washington Hospital, funded by Department of Health and Human Services, Public Health Service
(7/1/80-6/30/85: $713,000)

Principal Investigator, renewal of the Faculty Fellowship in Family Medicine, funded by the Robert Wood Johnson Foundation
(7/1/84-6/30/87: $1,219,103)

Co-Principal Investigator, The Rural Hospital Project to devise model rural hospital service configurations for six rural hospitals in the WAMI region, funded by the W. K. Kellogg Foundation
(12/1/83-11/30/87: $1,268,827)

Principal Investigator, Supplemental Grant for University Hospital Family Medicine Residency Program, funded by

Department of Health and Human Services, Public Health Service
(7/1/85-6/30/85: $54,862)

Principal Investigator, Family Medicine Residency Training Grant involving University of Washington Hospital, funded by Department of Health and Human Services, Public Health Service
(7/1/85-6/30/88: $580,139)

Principal Investigator, Department of Family Medicine Grant, University of Washington, funded by Department of Health and Human Services, Public Health Service
(9/1/86-8/31/89: $427,634)

Principal Investigator, Family Medicine Residency Training Grant involving University of Washington Hospital, funded by Department of Health and Human Services, Public Health Service
(7/1/88-6/30/91: $345,000)

Principal Investigator, Department of Family Medicine Grant, University of Washington, funded by Department of Health and Human Services, Public Health Service
(9/1/89-8/31/92: $534,021)

Principal Investigator, Department of Family Medicine Grant, University of Washington, funded by Lutheran Health Systems, Fargo, North Dakota, and Northwest Area Foundation, St. Paul, Minnesota
(9/1/91-8/31/94: $300,000)

SELECTED PRESENTATIONS:

3/73 "Obstetrics and Family Practice: Conflict in Medical Education?" Annual Meeting of Association of Professors of Obstetrics and Gynecology, New Orleans, Louisiana

7/73 "The Model Family Practice Unit in a University Program." Fifth Annual Workshop for Developing Programs in Family Practice, Kansas City, Missouri

11/74 "Methods of Continuing Education for the Practicing Physician." Sixth World Conference on General Practice and Family Medicine, Mexico City, Mexico

6/75 "The Practicing Family Physician as a Student and Teacher." Workshop for Directors of Family Practice Residencies, Kansas City, Missouri

3/76 "Goals and Objectives of a Family Practice Residency Training Program." 1976 Annual Workshop for Developing Programs in Family Practice, American Academy of Family Physicians, Kansas City, Missouri

3/77 "Perceptions of Formal In-Training Evaluation by Family Practice and Internal Medicine Residents." North American Primary Care Research Group, Richmond, Virginia

3/77 "Regionalized Family Medicine Residency Programs." Thirtieth National Conference on Rural Health, Seattle, Washington

5/78 "Meet the Editors." U.S. Representative to WONCA Meeting (Eighth World Conference on Family Medicine/General Practice), Montreux, Switzerland

4/79 "Research in Primary Care." Annual Meeting of North American Primary Care Research Group, Seattle, Washington

5/79 "Graduate Education in Family Practice: A Ten-Year View." Annual Meeting of Society of Teachers of Family Medicine, Denver, Colorado

4/80 "Goals for Family Practice in 1990." State University of New York, Stony Brook, New York

11/80 "Family Practice - Then and Now." George Firestone, M.D., Memorial Lecture, University of California, School of Medicine, Santa Rosa, California

5/81 "Behavioral Science and Family Medicine: Theory and Practice." Association for Behavioral Science and Medical Education, Quinault, Washington

11/81 "Evaluation of Teaching Performance in Family Medicine." Association of Departments of Family Medicine, Washington, D.C.

11/81 "Career Tracks in Academic Family Medicine: Problems and Approaches." Society of Teachers of Family Medicine, Asilomar, California

5/83 "Treatment of Mild Hypertension." "An Editor's View of the Peer Review Process." Annual Meeting of Royal College of General Practitioners, Dunedin, New Zealand

5/83 "Family Practice Journals and Information Needs in Family Practice." Tenth WONCA World Conference on Family Medicine, Singapore

10/83 "Relevance of Tenure to the Career of a Family Physician." Western Regional Meeting of Society of Teachers of Family Medicine, Long Beach, Washington

9/84 "Teaching Continuity of Care in Family Practice." Western Regional Meeting of Society of Teachers of Family Medicine, Seattle, Washington

9/84 "Journals for Family Practice." Advanced Forum in Family Medicine, Keystone, Colorado

7/85 "Evolution of the Family Practice Residency." Third Family Medicine Seminar, Nikko, Japan

11/85 "The Family Physician as a Specialist in the Medical Education System." Greek-USA Family Practice Symposium

12/85 "Changing Trends in Primary Care and Family Medicine." Ben Gurion University of the Negev, Hebrew University and University of Tel-Aviv, Israel

5/86 "Primary Medicine for the 21st Century: What Are the Options?" Eighth Annual Meeting of Robert Wood Johnson Foundation's Family Practice Fellowship Programs, San Diego, California

11/86 "Future Trends in Primary Care and Family Practice." Keynote Address, Research Day X, Michigan State University, Lansing, Michigan

4/87 "Interface of General Internal Medicine and Family Medicine." Annual Meeting of Society for Research and Education in Primary Care Internal Medicine, San Diego, California

9/88 "Beyond the Plateau: Alternative Future Scenarios for Family Practice and Primary Care." Advanced Forum in Family Medicine, Keystone, Colorado

11/88 "Future Directions for Departments of Family Medicine." Meeting of Association of Departments of Family Medicine, Chicago, Illinois

12/88 "Research, the Literature, and Family Medicine as an Academic Discipline." Third Annual Primary Care Research Methods and Statistics Conference, University of Texas, San Antonio

4/89 "Options for Training Generalist Physicians for 21st Century." Endicott House, Cambridge. Josiah Macy Jr. Foundation

5/89 "General Issues in Medicare Financing of Family Practice and Primary Care Residencies." Society of Teachers of Family Medicine, Denver, Colorado

10/89 "Organizational Alternatives for Academic Family Medicine." Meeting of Association of Departments of Family Medicine. Washington, D.C.

2/90 "The Department of Family Medicine and the Area Health Education Center." Meeting of Association of Departments of Family Medicine, Palm Springs, California

5/90 "Family Medicine as an Academic Discipline: Progress, Challenges, and Opportunities." Society of Teachers of Family Medicine, Seattle, Washington

2/91 "Planning for the Future of a Department of Family Medicine." Meeting of Association of Departments of Family Medicine. Tampa, Florida

10/91 "Family Practice in Evolution: Reflections on Change." Second Annual B. Leslie Huffman Lecture, Medical College of Ohio, Toledo, Ohio

3/92 "Family Practice in Evolution: Progress and Lessons from Initial Experience." Annual Meeting of Chinese Taipei Association of Family Medicine, Taipei, Taiwan

4/92 "Common Mistakes in Writing a Journal Article:, Meeting of the Society of Teachers of Family Medicine, St. Louis, Missouri

7/92 "Family Practice: Then and Now", Department of Family Medicine, University of Nevada, Reno

1/93 Editors' Roundtable, Third Primary Care Research Conference, Agency for Health Care Policy and Research, Atlanta, Georgia

JOURNAL ARTICLES:

1. Geyman JP: Osteogenesis imperfecta and pregnancy. Calif Med 107:171-172, August 1967
2. Geyman JP: A coronary care unit in a 25-bed rural hospital. Calif Med 112:74-77, 1970
3. Geyman JP: Sonoma county hospital residency program. California GP, pp 13-18, January/February 1970
4. Geyman JP: Acute iliofemoral thrombophlebitis during pregnancy case report. Clinical Medicine 77:21-23, November 1970
5. Geyman JP: Anaphylactic reaction to oral penicillin. Calif Med 114:87-89, May 1971
6. Geyman JP: Conversion of the general practice residency to family practice. JAMA 215:1801-1807, March 1971
7. Geyman JP: Family practice and the medical school. California GP, pp 8-14, March/April 1971
8. Geyman JP: The University of Utah Division of Family Practice goals and early directions. Utah Family Physician, pp 30-36, Summer 1971
9. Geyman JP: Family medicine as an academic discipline. J Med Educ 46:815-820, October 1971
10. Geyman JP: A modular basis of resident training for family practice. J Med Educ 47:292-293, April 1972
11. Geyman JP: The new family practice residencies. California GP, pp 7-10, July/August 1973
12. Geyman JP: Obstetrics and family practice: Conflict in medical education? J Reprod Med 12(2):59-63, 1974

13. Geyman JP: A competency-based curriculum as an organizing framework in family practice residencies. J Fam Pract 1(1):34-38, 1974

14. Burr BD, Bonanno JA, Geyman JP, et al: Cardiac surgery for congenital heart disease in a multi-problem family. J Fam Pract 1(1):64-69, 1974

15. Geyman JP: Family practice residencies in community hospitals. Supplement to Am Fam Physician, pp 1-9, July 1974

16. Geyman JP, Guyton R: Evaluation of multimedia self-teaching programs for medical students taking community preceptorships. J Med Educ 49:1062-1064, 1974

17. Geyman JP, Brown TC: A developing regional network residency program in family practice. West J Med 121:514-520, 1974

18. Geyman JP: A new look at continuing education in family practice. J Fam Pract 2(2):119-122, 1975

19. Geyman JP, Brown TC: A teaching bank of audio-visual materials in family practice. J Fam Pract 2(5):359-363, 1975

20. Geyman JP: Continuity of care in family practice: Implementing continuity in a family practice residency program. J Fam Pract 2(6):445-447, 1975

21. Geyman JP, Brown TC, Ribers K: Referrals in family practice: A comparative study by geographic region and practice setting. J Fam Pract 3(2):163-167, 1976

22. Geyman JP: Continuing medical education in a family practice residency. California GP, pp 10-12, May/June 1976

23. Geyman JP, Brown TC: An in-training examination for residents in family practice: A pilot study. J Fam Pract 3(4):409-413, 1976

24. Geyman JP: Evaluating family practice residencies. The New Physician 25(9):35-37, 1976

25. Geyman JP, Brown TC: A network model for decentralized family practice residency training. J Fam Pract 3(6):621-627, 1976

26. Geyman JP: The practicing family physician as a teacher and learner in a family practice residency. AHME Journal, 30-31, January 1977

27. Geyman JP: The "one-and-two" family practice residency program, Supplement to Am Fam Physician, February 1977

28. Geyman JP: Phase two of the University of Washington Department of Family Medicine. Washington Family Physician, 6-10, Spring 1977

29. Geyman, JP, Brown TC: Evaluation of audiovisual teaching materials in family practice: A report of review activities 1974-76. J Fam Pract 4(5):903:918, 1977

30. Geyman JP: Prevention of complications in initial development of family practice residency programs. J Fam Pract 4(6): 1111-1115, 1977

31. Leaman TL, Geyman JP, Brown TC: Graduate education in family practice. J Fam Pract 5(1):47-61, 1977

32. Geyman JP: Research in the family practice residency program. J Fam Pract 5(2):245-248, 1977

33. Geyman JP: Recent developments and future directions in family practice. University of Washington Medicine 4(3): 17-24, Fall, 1977

34. Geyman JP: The family as the object of care. J Fam Pract 5(4):571-575, 1977. Reprinted in South Dakota J of Med XXXI(4):29-34, April 1978

35. Geyman JP, Brown TC, Lee P: Perceptions of formal in-training evaluation by family practice residents. J Fam Pract 5(5):869-870, 1977

36. Geyman JP: The "one-and-two" program: A new direction in family practice residency training. J Med Educ 52:999-1001, 1977

37. Geyman JP: Family practice in evolution: Progress, problems and projections. N Engl J Med 298:593-601, 1978

38. English EC, Geyman JP: The efficiency and cost-effectiveness of diagnostic tests for infectious mononucleosis. J Fam Pract 6(5):977-981, 1978

39. Shortell SM, Dowling WL, Foster R, Urban N, Williams SJ, Geyman JP, Phillips TJ, Richardson WC, and Ross A: Hospital-sponsored primary care: Organizational and financial issues. Medical Group Management 25(3):16-22, May/June 1978

40. Geyman JP: Climate for research in family practice. J Fam Pract 7(1):69-74, 1978

41. Geyman JP, Bass MJ: Communication of results of research. J Fam Pract 7(1):113-120, 1978

42. Geyman JP, Deisher JB, Gordon MJ: A family practice residency network: Affiliated programs in the Pacific Northwest. JAMA 240(4):369-371, 1978

43. Geyman JP, Erickson S: The ampicillin rash as a diagnostic and management problem: Case reports and literature review. J Fam Pract 7(3):493-496, 1978

44. Geyman JP, Gordon MJ: Orthopedic problems in family practice: Incidence, distribution and curricular implications. J Fam Pract 8(4):759-765, 1978

45. Geyman JP: Family practice in the United States: The first ten years, J Royal Coll Gen Pract 29:289-296, 1979

46. Geyman JP: Evaluation of audiovisual teaching materials in family practice: A report of review activities, 1977-1978. J Fam Pract 8(5):985-1001, 1978

47. Geyman JP: Family Practice finds a home in the hospital. Hosp Med Staff 8(10):14-20, 1979

48. Geyman JP: The Department of Family Medicine at the University of Washington: A progress report. The Washington Family Physician 6(4):6-9, 1979

49. Geyman JP: Graduate education in family practice: A ten-year view. J Fam Pract 9(5):859-871, 1979

50. Geyman JP: A specialty-specific approach to appraisal of audiovisual teaching materials. J Med Educ 54(12):950-952, 1979

51. Geyman JP, Cherkin DC, Deisher JB, Gordon MJ: Graduate follow-up in the University of Washington Family Practice Residency Network. J Fam Pract 11(5):743-752, 1980

52. Geyman JP, Cherkin DC, Wood M, Ciriacy E: Geographic distribution of family practice residency graduates: The experience of three statewide networks. J Fam Pract 11(5):761-766, 1980

53. Geyman JP: Evaluation of audiovisual teaching materials in family practice: A report of review activities, 1979-1980. J Fam Pract 12(2):263-277, 1981

54. Geyman JP: Future medical practice in the United States: A choice of scenarios. JAMA 245(11):1140-1143, 1981

55. Geyman JP: Education for the practice of family medicine. Marriage and Family Review 4(1/2): 103-112, 1981. Reprinted in Cogswell BE, Sussman MB (eds): Family Medicine: A New Approach to Health Care. New York, Hayworth Press, 1982

56. Parkerson GR, Barr D, Bass MJ, Bland CJ, Froom J, Geyman JP, et al: Meeting the challenge of research in family medicine. J Fam Pract 14(1):105-113, 1982

57. Geyman JP, Phillips TJ: A University Department of Family Medicine after ten years. West J Med 136:170-178, 1982

58. Geyman JP: Career tracks in academic family medicine: Issues and approaches. J Fam Pract, 14(1):911-917, 1982

59. Geyman JP, Gordon MJ: Learning outcomes and practice changes after a postgraduate course in office orthopedics. J Fam Pract 15(1):131-136, 1982

60. Geyman, JP, and Kirkwood CR: Telescopic laryngoscopy. J Fam Pract 16(4):789-791, 1983

61. Geyman JP: Citation analysis of the Journal of Family Practice. J Fam Pract 16(4):812-819, 1983

62. Geyman JP: The Department of Family Medicine at the University of Washington: An updated progress report. The Washington Family Physician 10(2):8-11, 1983

63. Geyman JP: The Oslerian tradition and changing medical education: A reappraisal. West J Med 138:884-888, 1983

64. Geyman JP: Dying and death of a family member. J Fam Pract 17(1):125-134, 1983

65. Geyman JP, Berg AO: The Journal of Family Practice 1974-1983: Analysis of an evolving literature base. J Fam Pract 18(1):47-51, 1984

66. Geyman JP, Deyrup JA: Physicians for the twenty-first century: Subgroup report on teamwork skills. J Med Educ 59(11):169-172, 1984

67. Geyman JP, Gordon MJ: Ophthalmology training in U.S. family practice residency programs. J Fam Pract 22(3):273-276, 1986

68. Geyman JP: Training primary care physicians for the 21st century: Alternative scenarios for competitive versus generic approaches. JAMA 255(19):2631-2635, 1986

69. Geyman JP: Trends in primary care practice and education in developed countries. Family Physician, Israel 14(3):38,252-262, 1987

70. Geyman JP: Future trends in primary care and family practice. Japanese Journal of Family Practice 3(2):271-277, 1987

71. Geyman JP, Berg, AO: The Journal of Family Practice, 1974-1988: Window to an evolving academic discipline. J Fam Pract 28(3):301-304, 1989

72. Schneeweiss R, Ellsbury K, Hart G, Geyman JP: The economic impact and multiplier effect of a family practice clinic on an academic medical center. JAMA 262(3):370-375, 1989

73. Geyman JP: Family medicine as an academic discipline: Progress, challenges, and opportunities. J Fam Pract 31(3):297-303, 1990

74. Taylor RB, Colwill JM, Puffer JC, Heffron WA, Marsladn DW, Rakel RE, Geyman JP: Success strategies for Departments of Family Medicine. J Am Bd Fam Pract 4:6, 427-436, 1991

EDITORIALS:

1. Geyman JP: Family practice: A diagnosis. U.S. Medicine, Vol 7, March 1971

2. Geyman JP: A family practice clerkship in your hospital? California GP, pp 12-14, May/June 1971

3. Geyman JP: Expanded literature base as a critical need in family practice. J Fam Pract 1(1):4, 1974

4. Geyman JP: On avoiding town-gown issues in family practice. J Fam Pract 1(2):6-7, 1974

5. Geyman JP: On the discovery of primary care. J Fam Pract 1:3/4:3, 1974

6. Geyman JP: Toward a research base in family practice. J Fam Pract 2(1):3, 1974

7. Geyman JP: Toward more rational health screening. J Fam Pract 2(1):83, 1975

8. Geyman JP: Ambulatory medicine as a career option. J Fam Pract 2(6):405, 1975

9. Geyman JP: Toward the definition of family practice: A quantum jump. J Fam Pract 3(1):23, 1976

10. Geyman JP: On defining quality in family practice education. J Fam Pract 3(2):133, 1976

11. Geyman JP: On depersonalization in medicine. J Fam Pract 3(3):239, 1976

12. Geyman JP: Family practice and changing patterns of obstetric care. J Fam Pract 3(4):359, 1976

13. Geyman JP: On the organizational family in family practice. J Fam Pract 3(5):463, 1976

14. Geyman JP: On entry into phase two in family practice development. J Fam Pract 4(1): 15, 1977

15. Geyman JP: On the need for critical inquiry in family medicine. J Fam Pract 4(2):195, 1977

16. Geyman JP: Family practice in an era of limits. J Fam Pract 4(3):411, 1977

17. Geyman JP: The developing academic base of family practice in the medical school. J Fam Pract 5(1):35-36, 1977

18. Geyman JP: Toward performance-based continuing medical education. J Fam Pract 5(3):333, 1977

19. Geyman JP: Family practice residencies and the continuum of medical education. J Fam Pract 5(5):743, 1977

20. Geyman JP: Is nursing practice different from medical practice? J Fam Pract 5(6):935-936, 1977

21. Geyman JP: On the developing literature base in family practice. J Fam Pract 6(1):33-34, 1978

22. Geyman JP: Insecurity in medical education: A preventable problem? J Fam Pract 6(2):229-230, 1978

23. Geyman JP: On the plight of the rural hospital. J Fam Pract 6(3):477-478, 1978

24. Geyman JP: On growth and development of individuals and families. J Fam Pract 6(4):739, 1978

25. Geyman JP: Progress of faculty development in family practice. J Fam Pract 6(5):953-954, 1978

26. Geyman JP: On the developing research base in family practice. J Fam Pract 7(1):51-52, 1978

27. Geyman JP: How many family physicians are needed? J Fam Pract 7(2):257-258, 1978

28. Geyman JP: WONCA, international sharing and research in general family practice. J Fam Pract 7(3):431, 1978

29. Geyman JP: Specialty maldistribution and the technological imperative. J Fam Pract 7(4):669-670, 1978

30. Geyman JP: Graduate medical education and the territorial imperative. J Fam Pract 7(5):919-920, 1978

31. Geyman JP: Geriatrics in family practice education. J Fam Pract 7(6):1092-1094, 1978

32. Geyman JP: The Journal of Family Practice: 1974-1979. J Fam Pract 8(1):19-20, 1979

33. Geyman JP: Toward the definition of orthopedic care in family practice. J Fam Pract 8(4):699, 1978

34. Geyman JP: Hospital practice of the family physician. J Fam Pract 8(5):911-912, 1979

35. Geyman JP: Changing national priorities in medical education and primary care. J Fam Pract 8(6):1117-1118, 1979

36. Geyman JP: Preventive medicine in family practice: A reassessment. J Fam Pract 9(3):35-36, 1979

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38. Geyman JP: The National Health Service Corps: Panacea, partial solution or potential fiasco? J Fam Pract 9(3):381-382, 1979

39. Geyman JP: How effective is the "hidden system" of primary care? J Fam Pract 9(4):563-564, 1979

40. Geyman JP: Clinical departments of family practice in hospitals. J Fam Pract 9(5):791-792, 1979

41. Geyman JP: Alternatives for funding family practice teaching programs. J Fam Pract 9(6):1003-1004, 1979

42. Geyman JP: Clinical pharmacy in family practice. J Fam Pract 10(1):21-22, 1980

43. Geyman JP: Increasing number of women in family practice: An overdue trend. J Fam Pract 10(2):207-208, 1980

44. Geyman JP: Systematic evaluation of medical technology: An urgent need. J Fam Pract 10(3):403-404, 1980

45. Geyman JP: Expanding concerns and applications of medical ethics. J Fam Pract 10(4):595-596, 1980

46. Geyman JP: How effective is patient education. J Fam Pract 10(6):973-974, 1980

47. Geyman JP: Trends and concerns in emergency room utilization. J Fam Pract 11(1):23-24, 1980

48. Geyman JP: Health services research: A crucial and underfunded need. J Fam Pract 11(2):195-196, 1980

49. Geyman JP: Pediatric training in family practice residencies. J Fam Pract 11(4):531-532, 1980

50. Geyman JP: The emerging profile of the residency trained family physician. J Fam Pract 11(5):717-718, 1980

51. Geyman JP: Consensus-development for research and patient care. J Fam Pract 11(6):843-844, 1980

52. Geyman JP: Family practice residencies and their sponsoring hospitals: Mutual interests and unrecognized potential. J Fam Pract 11(7):1019-1021, 1980

53. Geyman JP: Geriatrics, specialism and primary care. J Fam Pract 12(1):15-17, 1981

54. Geyman JP: Screening for glaucoma in family practice. J Fam Pract 12(3):423-424, 1981

55. Geyman JP: Mental health care in family practice. J Fam Pract 12(4):615-616, 1981

56. Geyman JP: Toward a middle ground in the technology debate in obstetric care. J Fam Pract 12(6):971-972, 1981

57. Geyman JP: Hospital privileges of family physicians. J Fam Pract 13(3):325-326, 1981

58. Geyman JP: Funding patient care, education and research in family practice: Interrelated system problems. J Fam Pract 13(4):495-496, 1981

59. Geyman JP: The literature of record in family practice: Progress, problems and needs. J Fam Pract 13(5):591-592, 1981

60. Geyman JP: Reimbursement for mental health services in family practice: Lessons from the Canadian experience. J Fam Pract 13(6):795-796, 1981

61. Geyman JP: Student selection of family practice residencies: A ten-year view. J Fam Pract 13(7):971-972, 1981

62. Geyman JP: International sharing through the family practice literature. J Fam Pract 14(1):15-16, 1982

63. Geyman JP: Training for primary care: A family practice perspective. West J Med 136:83-84, 1982

64. Geyman JP: Teaching general and family practice. Medical Teacher 4(1):4-5, 1982

65. Geyman JP: Drug treatment of mild hypertension: A continuing debate. J Fam Pract 14(5):819-820, 1982

66. Geyman JP: Faculty development and evaluation of teaching performance. J Fam Pract 14(6):987-988, 1982

67. Geyman JP: Inappropriate drug prescribing: A soluble problem? J Fam Pract 15(1):15-18, 1982

68. Geyman JP: Public perceptions of psychosocial problems and roles of the family physicians. J Fam Pract 15(2):225-226, 1982

69. Geyman JP: Pediatric health care in family practice. J Fam Pract 15(6):1048-1049, 1982

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73. Geyman JP: Medical graduates opting for family practice: A reassessment. J Fam Pract 17(2):183-184, 1983

74. Geyman JP: Computers in family practice. J Fam Pract 17(3):377-378, 1983

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79. Geyman JP: The computer and information management in family practice. J Fam Pract 19(1):39, 1984

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	JOINT MOTION FOR ENTRY OF FINAL JUDGMENT
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

The parties jointly move the court, pursuant to Fed. R. Civ. P. 54(b), to determine that there is no just reason for delaying entry of a final judgment as to those claims

addressed in the Court's Order Granting in Part and Denying in Part Plaintiffs' Motion for Summary Judgment and Denying Defendant's Cross-Motion for Summary Judgment, and to direct entry of a final judgment as to those claims. This motion is based on the Stipulation of the Parties Regarding Finality of the Court's Order and Appeal, and the parties Joint Memorandum in Support of Rule 54(b) Entry of Final Judgment, both of which are filed herewith, and is intended to facilitate an expeditious appeal of the Court's order by the defendants.

DATED this 19th day of May, 1994.

CHRISTINE O. GREGOIRE
Attorney General

/s/
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of Washington
and Christine O. Gregoire,
Attorney General

PERKINS COIE

/s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	STIPULATION OF THE PARTIES REGARDING FINALITY OF COURT'S ORDER AND APPEAL
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

The parties stipulate as follows:

1. Defendants intend to pursue an appeal of the Court's order granting partial summary judgment. It is in the best interest of all of the parties, and of the public, that such an appeal be pursued as expeditiously as possible.

2. If the Court enters a final judgment as to those claims addressed in the Order dated May 3, 1994, granting partial summary judgment as to some of plaintiffs' claims, any further action with respect to any remaining claims of the plaintiffs shall be deferred pending final resolution of the defendants' appeal of the Court's order granting partial summary judgment. This does not preclude the possibility that plaintiffs may pursue injunctive relief should events develop that warrant doing so.

3. Any petition by plaintiff for attorneys' fees shall be deferred pending final resolution of the defendants' appeal of the Court's order granting partial summary judgment.

4. This stipulation is for the purpose of facilitating appellate review of the Court's order granting partial summary judgment. By signing this stipulation, the parties shall not be deemed to have waived or in any way limited their respective legal arguments in this case.

DATED this 19th day of May, 1994.

CHRISTINE O. GREGOIRE
Attorney General

/s/
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of Washington
and Christine O. Gregoire,
Attorney General

PERKINS COIE

/s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

FILED/ENTERED
MAY 20 1994
AT SEATTLE
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

LODGED
MAY 19 1994
AT SEATTLE
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	ORDER ENTERING FINAL JUDGMENT
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

IT IS HEREBY ORDERED that judgment be entered forthwith as to the claims resolved by the May 3, 1994 decision of this Court, and the clerk is directed to enter such judgment.

It is expressly determined by this Court that there is no just reason for delay in the entry of final judgment until final determination of all the issues involved in the above-entitled action.

DATED this 20th day of May, 1994.

/s/
Honorable Barbara J. Rothstein
United States District Court Judge

Presented by:

PERKINS COIE

By: /s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

CHRISTINE O. GREGOIRE
ATTORNEY GENERAL

By:_____/s/_____
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of Washington
and Christine O. Gregoire, Attorney
General of Washington

The parties' joint motion to shorten time is hereby GRANTED. [initials BJR]

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

File Number C94-119

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NOTICE OF APPEAL
Plaintiffs,	)	
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

FILED MAIL
MAY 20 1994
AT SEATTLE
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

ENTERED
ON DOCKET
JUN 01 1994
By Deputy MG

Notice is hereby given that the State of Washington and Christine Gregoire, Attorney General of Washington, defendants, in the above named case, hereby appeal to the United States Court of Appeals for the Ninth Circuit from the judgment entered in this action on May 20, 1994.

DATED this 24th day of May, 1994.

CHRISTINE GREGOIRE
Attorney General

/s/
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of
Washington and Christine O.
Gregoire, Attorney General